Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Quality and Outcomes Framework guidance for GMS contract 2016/17

Guidance for the Regional Board and practices

September 2016

Contents

Section 1: Introduction

The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary.

QOF was introduced as part of the new GMS contract in 2004.

From April 2013 NHS Employers ceased to coordinate QOF on behalf of the four UK health departments and the then DHSSPS in conjunction with HSCB and NIGPC, agreed a number of changes to QOF for that year. From 2014 a forum has been created to include Northern Ireland, Scotland and Wales to deliver a harmonised approach for the three countries.

This document includes a copy of the summary of indicators for the 2016/17 QOF as set out in Annex D of the General Medical Services (GMS) Statement of Financial Entitlements Directions (SFE) and provides additional guidance on the indicators in Northern Ireland. It replaces all guidance issued in previous years. Annex D to the SFE forms part of the GMS contract for 2016/17.

For 2016/17 the Department agreed specific changes for Northern Ireland with NIGPC, the majority of which focus on changes to QOF and maintain current levels of investment in General Practice.

The term Regional Board (Regional Health & Social Care Board) is used throughout the guidance, as the structure responsible for the commissioning of primary care in Northern Ireland.

Principles

The following principles relating to the QOF have been agreed by the negotiating parties:

1. Indicators should, where possible, be based on the best available evidence.

2. The number of indicators in each clinical condition should be kept to the minimum number compatible with an accurate assessment of patient care.

3. Data should never be collected purely for audit purposes.

4. Only data which is useful in patient care should be collected. The basis of the consultation should not be distorted by an over emphasis on data collection. An appropriate balance has to be struck between excess data collection and inadequate sampling.

5. Data should never be collected twice e.g. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

General information on indicators

Where the timeframe, payment threshold, points value or other detail differ in Northern Ireland to Scotland and Wales "NI" has been added to the number. In Section 3 the NI tag is on the indicator both in the table and each subsection but has not been added throughout the text where the meaning is unchanged. For example the indicator is AF006NI but "Rationale" is simply numbered AF006.1 as it applies equally to all versions.

For the purposes of calculating achievement payments, contractor achievement against QOF indicators is measured:

- on the last day of the relevant financial year (31 March); or

- in the case where the contract terminates mid-year, on the last day on which the contract subsists. For example, for payments relating to the financial year 1 April 2016 to 31 March 2017, unless the contract terminates mid-year, achievement is measured on 31 March 2017. If the GMS contract ends on 30 June 2016, achievement is measured on 30 June 2016.

Indicators generally set out the target, intervention or measurement to be recorded within a specified time period to establish eligibility for achievement payments. Unless otherwise stated, time periods referred to mean the period which ends on the last day of the financial year to which the achievement relates. For example:

- Indicator CHD002– "*The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less"*, the phrase "in the preceding 15 months" means the period of 15 months which ends on 31 March in the financial year to which the achievement payments relate.

For clarity, the following points apply to any indicators in which age or date ranges are referenced:

- Where an indicator refers to the financial year, this means the period of 15 months from 1 April to 31 March with a 3 month overlap from the previous year.

- Where an indicator refers to patients diagnosed after a specified date (and does not specify a period within which the care described in the indicator is to be carried out), the indicator is looking for any record of the care described at any time on or after the diagnosis date (provided that the diagnosis date is on or after the specified date) up to and including the date that the achievement is measured. This type of indicator is called a "cumulative" indicator. AST002 is an example '*The percentage of patients aged 8 years or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis*'. This indicator is looking for any record of the specified care at any time on or after the diagnosis date (provided that the diagnosis date is on or after 1 April 2006), up to and including the date that the achievement is measured.

- Patients are considered to be 'currently treated' with a specified medicine if they have had a prescription for that medicine within the preceding six months ending on the last day of the financial year to which the achievement payments relate.

In the case of a contract that has come to an end before 31 March in any relevant financial year , the reference to periods of time are still calculated on the basis that the period ends on 31 March in the financial year to which the achievement payment relates. Annex D of the SFE sets out the rules that apply to measuring achievement for contracts that end before the end of the financial year.

Disease registers

An important feature of the QOF is the establishment of disease registers. These are lists of patients registered with the contractor who have been diagnosed with the disease or risk factor described in the register indicator. While it is recognised that these may not be completely accurate, it is the responsibility of the contractor to demonstrate that it has systems in place to maintain a high quality register. Verification may involve asking how the register is constructed and maintained. The Regional Board may compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations. Payment for disease registers has been transferred to Global Sum for the majority of clinical indicators and establishment and maintaining of registers remains critical to achievement of other indicators.

For some indicators, there is no disease register, but instead there is a target population group. For example, for cervical screening the target population group is women who are aged 25 years or over and under the age of 65.

Some areas in the clinical domain do not have a register indicator, or there may be more than one register to calculate the Adjusted Disease Prevalence Factor (ADPF) for different indicators within the area. For all relevant disease areas, the register population used to calculate the APDF are set out in the summary of indicators section.

Indicators in the records and systems (R&S) and patient experience (PE) domain have indicators which require a particular activity to be carried out and where the points available are awarded in full if it is carried out or not at all if it is not carried out.

Verification

For indicators where achievement is not extracted automatically from GP clinical systems the guidance outlines the evidence which the Regional Board may require the contractor to produce for verification purposes. The evidence would not need to be submitted unless requested by the Regional Board.

The SFE sets out the reporting requirements for contractors and the rules for the calculation of QOF payments. It states (see section 5.17 (c) - (d) of the directions):

(c) "a contractor utilising computer systems approved by the Regional Board must make available to the Regional Board aggregated monthly returns relating to their achievement

of the standards contained in the indicators in the QOF, and in the standard form provided for by such systems;

(d) all information supplied pursuant to or in accordance with this paragraph must be accurate."

The SFE states (section 6.4) that in order for a contractor claim payment for achievement *"a contractor must make a return in respect of the information required by it by the Regional Board in order for the Regional Board to calculate its achievement payment"*.

The SFE states (paragraph D16): "*The contractor must ensure that it is able to provide any information that the Regional Board may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled, and the contractor must make that information available to the Board on request. In verifying that an indicator has been achieved and information correctly recorded, the Regional Board may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator".*

Where 'reporting and verification' is included it provides additional information to support practices in meeting the criteria for the indicator.

The terms 'notes' and 'patient record' are used throughout this document to indicate either electronic or paper patient records.

Business rules

In April 2010, the NHS Health and Social Care Information Centre (HSCIC) took over the development of the Business Rules from NHS Employers and NHS Connecting for Health. The Logical Query Indicator Specification and the Dataset and Business Rules that support the reporting requirements of the QOF are based entirely on Read codes (version 2 and Clinical Terms Version 3) and associated dates. Read codes are an NHS standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QOF reporting. Contractors utilising such systems may need to develop strategies to ensure that they are using appropriate Read codes in advance of producing their achievement report.

Exception reporting

Exception reporting applies to those indicators in any domain of the QOF where the achievement is determined by the percentage of patients receiving the specified level of care.

Some indicators refer to a sub-set of patients on the relevant disease register, or in the target population group. Patients who are on the disease register or in the target group for the clinical area concerned, but not included in an indicator denominator for definitional reasons are called "exclusions".

"Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Patients are removed from the denominator and numerator for an indicator if they have been both excepted and they have not received the care specified in the indicator wording. If the patient has been excepted but subsequently the care has been carried out within the relevant time period the patient will be included in both the denominator and the numerator (e.g. achievement will always override an exception).

Exception reporting criteria
Patients may be excepted if they meet the following criteria for exception reporting:

A. Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the financial year to which the achievement payments relate (except in the case of indicator CS002NI, where the patient should have been invited on at least three occasions during the period of time specified in the indicator during which achievement is to be measured (e.g. the preceding five years ending on 31 March in the financial year to which achievement payments relate).

B. Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail.

C. Patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels.

D. Patients who are on maximum tolerated doses of medication whose levels remain sub-optimal.

E. Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contra-indication or have experienced an adverse reaction.

F. Where a patient has not tolerated medication.

G. Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.

H. Where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease.

I. Where an investigative service or secondary care service is unavailable.

In the case of exception reporting on criteria A and B these patients are removed from the denominator for all indicators in that disease area where the care had not been delivered. For example, a contractor with 100 patients on the coronary heart disease (CHD) disease register, of which four patients have been recalled for follow-up on three occasions but have not attended and one patient has become terminally ill with metastatic breast

carcinoma during the year, the denominator for reporting would be 95. However, all 100 patients with CHD would be included in the calculation of ADPF (practice prevalence). This would apply to all relevant indicators in the CHD set.

In addition, contractors may exception report patients from single indicators if they meet criteria in C to I, for example a patient who has heart failure (HF) due to left ventricular systolic dysfunction (LVSD) but who is intolerant of angiotensin converting enzyme inhibitors (ACE-inhibitors/ACE-I) and angiotensin receptor blocker (ARB) could be exception reported from HF003. This would result in the patient being removed from the denominator for that indicator only.

Contractors should report the number of exceptions for each indicator set and individual indicator. Contractors will not be expected to report why individual patients were exception reported. However, contractors may be called on to explain why they have 'excepted' patients from an indicator and this should be identifiable in the patient record.

Additional guidance on exception reporting can be found in section eight of this document and in annex D of the SFE.

Section 2: Summary of all indicators

Section 2.1: Clinical domain

Section 2.1. applies to all contractors participating in QOF.

Atrial fibrillation (AF)

Indicator	Points	Achievement thresholds
Ongoing management		
AF006NI. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous $CHADS_2$ or CHA_2DS_2-VASc score of 2 or more)	12	40–90%
AF007. In those patients with atrial fibrillation whose latest record of a CHA_2DS_2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	10	40–70%

Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Achievement thresholds
Ongoing management		
CHD002. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	17	60-80%
CHD003NI. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less	17	65-75%
CHD007. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March	7	70-90%
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	70-90%

Heart failure (HF)

Indicator	Points	Achievement thresholds
Initial diagnosis		
HF002NI. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 15 months after entering on to the register	6	70–90%
Ongoing management		
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	10	65-80%
HF004. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure	9	40–65%

Disease registers for heart failure

There are two disease registers used for the HF indicators for the purpose of calculating APDF:

1. a register of patients with HF is used to calculate APDF for HF002
2. a register of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003 and HF004.

Register 2. is a sub-set of register 1 and is composed of patients with a diagnostic code for LVSD as well as for HF.

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Ongoing management		
HYP002NI. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	20	65-80%

Stroke and transient ischaemic attack (STIA)

Indicator	Points	Achievement thresholds
Initial diagnosis		
STIA008NI The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2016) who have a record of a referral for further investigation between 3 months before and 1 month after the date of the latest recorded stroke or the first TIA	2	65–80%
Ongoing management		
STIA003. The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15months) is 150/90 mmHg or less	5	60-80%
STIA004NI. The percentage of patients with stroke and is shown to be non-haemorrhagic or a history of TIA who have a record of total cholesterol in the preceding 3 years	2	50–90%
STIA005NI. The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less	5	60-70%
STIA009. The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March	2	65-90%
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken	4	70-90%

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Ongoing management		
DM002NI. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	8	65-75%
DM003NI. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15months) is 140/80 mmHg or less	10	40-65%
DM004NI. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 15 months) is 5 mmol/l or less	6	60-80%
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	65-80%
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months	17	40-50%
DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months	8	55-70%
DM009. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months	10	50-90%
DM010. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	65-90%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months	4	50–90%

DM015NI. The percentage of male patients with diabetes, on the register, with whom erectile dysfunction has been discussed. Where appropriate patients should have been offered advice/investigation/treatment.	4	40–90%

Asthma (AST)

Indicator	Points	Achievement thresholds
Initial diagnosis		
AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis	15	45–80%
Ongoing management		
AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions	20	45–70%
AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months	6	45–80%

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Initial diagnosis		
COPD002NI. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 15 months after entering on to the register	5	45–80%
Ongoing management		
COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months	9	70–90%
COPD004NI. The percentage of patients with COPD with a record of FEV_1 in the preceding 3 years	7	40–75%

COPD005NI. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 15 months	5	40-90%
COPD007. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	6	65-90%

Dementia (DEM)

Indicator	Points	Achievement thresholds
Ongoing management		
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months	15	55–70%
DEM003. The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before and 6 months after entering on to the register	6	45–80%

Depression (DEP)

Indicator	Points	Achievement thresholds
Initial diagnosis		
DEP001NI. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had an assessment of the physical, psychological and social aspects of the condition by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded	21	50–90%

Mental health (MH)

Indicator	Points	Achievement thresholds
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate	6	30-55%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months	4	50–90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months	4	50–90%
MH008NI. The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years	5	45–80%
MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months	1	50–90%
MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months	2	50–90%

Disease register for mental health

Due to the way repeat prescribing works in general practice, patients on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

Remission from serious mental illness

Making an accurate diagnosis of remission can be challenging. In the absence of strong evidence of what constitutes 'remission' from serious mental illness, clinicians should only consider using the remission codes if the patient has been in remission for at least five years, that is where there is:

- no record of anti-psychotic medication

- no mental health in-patient episodes; and
- no secondary or community care mental health follow-up for at least five years.

Where a patient is recorded as being 'in remission' they remain on the Mental Health register (in case their condition relapses at a later date) but they are excluded from the denominator for mental health indicators MH002-MH008NI.

The accuracy of this coding should be reviewed on an annual basis by a clinician. Should a patient who has been coded as 'in remission' experience a relapse then this should be recorded as such in their patient record.
In the event that a patient experiences a relapse and is coded as such, they will once again be included in all the associated indicators for schizophrenia, bipolar affective disorder and other psychoses.

Where a patient has relapsed after being recorded as being in remission, their care plan should be updated subsequent to the relapse. Care plans dated prior to the date of the relapse will not be acceptable for QOF purposes.

Cancer (CAN)

Indicator	Points	Achievement thresholds
Ongoing management		
CAN003. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis	6	50–90%

Osteoporosis: secondary prevention of fragility fractures

Indicator	Points	Achievement thresholds
Ongoing management		
OST002. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent	3	30–60%
OST005. The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent	3	30–60%

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months	5	40–90%
RA003NI. The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 3 years	7	40–90%
RA004. The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 3 years	5	40–90%

Palliative care (PC)

Indicator	Points	Achievement thresholds
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	
Ongoing management		
PC002. The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed	3	

Disease register for palliative care

There is no APDF calculation in respect of the palliative care indicators. In the rare case of a nil register at year end, if a contractor can demonstrate that it established and maintained a register during the financial year then they will be eligible for payment for PC001.

Section 2.2: Public Health domain

Section 2.2.1: Public health domain

Section 2.2.1. applies to all contractors participating in QOF.

Cardiovascular disease – primary prevention (CVD-PP)

Indicator	Points	Achievement thresholds
Ongoing management		
CVD-PP011NI. The percentage of patients with a new diagnosis of hypertension recorded in the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who are aged 30 or over and who have not attained the age of 75, who have a CVD risk assessment score recorded in the preceding 15 months.	5	40–90%
CVD-PP012NI. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score in the preceding 15 months of ≥20%: the percentage who are currently treated with statins.	5	40– 90%

Disease register for CVD-PP

The disease register for the purpose of calculating the APDF for the CVD-PP indicators is defined as follows: patients diagnosed with a first episode of hypertension on or after 1 April 2013, excluding patients with the following conditions:

- CHD or angina
- stroke or TIA
- peripheral vascular disease
- familial hypercholesterolemia
- CKD (stages 3-5)
- Diabetes

Blood pressure (BP)

Indicator	Points	Achievement thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure measurement in the preceding 5 years	15	50–90%

Smoking (SMOK)

Indicator	Points	Achievement thresholds
Records		
SMOK001NI. The percentage of patients aged 15 or over whose notes record smoking status in the preceding 3 years	10	50–90%

Requirements for recording smoking status

Smokers
For patients who smoke this recording should be made in the preceding 3 years for SMOK001.

Non-smokers
It is recognised that life-long non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 3 years for SMOK001NI.

Once a patient is over the age of 25 years (e.g. in the financial year in which they reach they age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:

- never smoked after their 25th birthday for SMOK001NI

Ex-smokers
There are two ways in which a patient can be recorded as an ex-smoker. Ex-smokers can be recorded as such in the preceding 3 years for SMOK001NI . Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.

Section 2.2.2: Public Health (PH) domain – additional services sub domain

Section 2.2.2. applies to contractors who provide additional services under the terms of the GMS contract and participate in QOF.

Cervical screening (CS)

Indicator	Points	Achievement thresholds
CS002NI. The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years	11	45–80%

Sexual health (CON)

Indicator	Points	Achievement thresholds
CON003NI. The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception in the preceding 3 years.	3	70–90%

Section 2.3. Records and Systems (RS) domain

Section 2.3. applies to all contractors participating in QOF.

Indicator	Points	Achievement thresholds
RS001. General Practitioners in the contracting practice should use Clinical Communications Gateway (CCG) for referrals to all available Consultant led specialities.[1]	10	n/a
RS002. The Practice reviews its own CCG Referral Data. Firstly to ensure that ALL GPs, including locums, are using CCG for referrals to all (available) Consultant led specialities. Secondly to look at referral patterns compared to previous years and neighbouring practices.[2]	20	n/a
RS003. The practice engages with between three and six neighbouring practices to discuss outpatient referrals. This should include identifying any issues with CCG use and looking at referral patterns and pathways.[3]	20	n/a
RS004. The Practice codes Emergency/Unplanned Admissions on receipt of the final paper or electronic discharge letter[4]. Information should include Date of Admission, Speciality and Diagnosis.	20	65%[5]
RS005. The Practice runs the Data Quality in Practice (DQiP) minimum dataset queries (to include queries to calculate the electronic frailty index[6]) in conjunction with the R&S tool, supported by the clinical informatics team on a six monthly basis. The extracts are shared with HSCB in pseudonymised form. The Practice will create and maintain a patient frailty register by coding patients identified by the electronic frailty index, presented in a dashboard in the R&S tool, using the appropriate Read code for mild, moderate or severe frailty.[7]	30	n/a

1 The aim is to use CCG for ALL referrals to ALL (available) specialities. The emphasis will remain on Consultant Led Specialities although GPs are encouraged to use CCG for other destinations as they are added.

[2] Reviewing referral patterns compared to previous years and neighbouring practices can be undertaken as a Quality Improvement and Clinical Governance exercise. Benchmarking information relating to January to June 2016 obtained from CCG and PAS databases will be made available to practices by 1st October 2016.

[3] Small Groups should consist of between three and six practices unless the HSCB agrees otherwise. This meeting should last 2-3 hours. Practices are expected to contribute significantly in discussions and no other parties should be present.

[4] Use the most relevant Read code under the 8H2 hierarchy **(see page 107)**

[5] The median rate of coding by GP Practices of unplanned admissions in July to December 2015 was 79% for uniquely coded admissions.

[6.] *Age and Ageing* 2016; **45:** 353–360

[7.] The Practice will be provided with a list of patients in each category of frailty, in the R&S tool, and the relevant Read code.

Section 2.4: Patient experience (PE) domain

Section 2.4. applies to all contractors participating in QOF.

Indicator	Points
PE001 NI The contractor undertakes a survey of patients who have had contact with the practice (face to face or telephone consultation or prescription) within the past year with the question "Would you recommend your GP practice to someone who has just moved into the local area?" **and one follow-up question (see below)** The contractor should survey at least 2% of the practice list size and need to get a minimum of 50 responses. A summary report is required to be submitted to the Regional Board by 31 March 2017	18

PE indicator 001 NI

The contractor undertakes a survey of patients who have had contact with the practice (face to face or telephone consultation or prescription) within the past year with the question

"Would you recommend your GP practice to someone who has just moved into the local area?"

1=extremely likely, 2=likely, 3=neither likely nor unlikely, 4=unlikely, 5=extremely unlikely, 6=don't know

In addition the contractor should include one follow-up question-

"Please can you tell us the main reason for the score you have given?" **OR**

"Please add any comments you would like to make about the practice?"

The contractor should survey at least 2% of the practice list size and need to get a minimum of 50 responses.

Section 3: Clinical domain

Clinical domain introduction

The clinical indicators are organised by disease category. The disease categories have been selected for the following reasons:

- where the responsibility for ongoing management rests principally with the general practitioner and the primary care team
- where there is good evidence of the health benefits likely to result from improved primary care – in particular if there is an accepted national clinical guideline
- where the disease area is a priority.

Where evidence-based national guidance has not been included, this has usually been to limit the size and complexity of the framework, where this is the case links and/or references have been included.

A summary of the indicators for each disease category is provided at the beginning of each section.

Establishing and maintaining disease registers is good professional practice and ensures a defined population is identified for undertaking further evidence-based interventions. Disease registers also make it possible to call and recall patients effectively to provide systematic care and to undertake care audits.

For each indicator detailed guidance supporting the indicator is provided under 'rationale' and where appropriate additional detail around 'reporting and verification' requirements are also included.

The drugs which count towards achievement for the clinical and health improvement indicators are included in the Business Rules for the relevant year. The code clusters within the Business Rules are updated each April and October. For this reason, references to acceptable drugs are not included in the guidance. The Business Rules can be found on the FPS Medical Services page of the Business Services Organisation (BSO) website http://www.hscbusiness.hscni.net/services/1785.htm

'xxx.1 Rationale'
This sub section explains why the indicator has been selected. Wherever possible, the evidence source is described and if available, a web address (hyperlink in an electronic version of this guidance) is provided. When available, national guidelines have been used as the main evidence source, but individual papers are also quoted. "NI" has not been added to the headings as the rationale is unchanged.

In some areas, more extensive information is provided. The aim is to achieve a balance of providing helpful information without attempting to provide a textbook of medicine or replicating guidelines.

The indicators included in the QOF are not intended to cover all the process issues or outcomes for each disease category. In some areas, the indicators cover only a very small part of the care for those conditions.

'xxx.2 Reporting and verification'

Annex D to the SFE sets out the requirements in relation to verification. The contractor is required to ensure that it is able to provide any information that the Regional Board may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled and the contractor is required to make that information available to the Regional Board on request. In verifying that an indicator has been achieved and information correctly recorded, the Regional Board may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator.

See section one for full details on reporting and verification.

Atrial fibrillation (AF)

Indicator	Points	Achievement thresholds
Ongoing management		
AF006NI. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a$CHADS_2$ or CHA_2DS_2-VASc score of 2 or more)	12	40–90%
AF007. In those patients with atrial fibrillation whose latest record of a CHA_2DS_2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	10	40–70%

AF – rationale for inclusion of indicator set

AF is the most common sustained cardiac arrhythmia in people aged 75 or over with a prevalence of 15 per cent. Much of the epidemiology of AF is derived from data from predominantly white populations, and information on AF in non-white populations is scarce In people who have had a stroke, concurrent AF is associated with greater disability, a longer stay in hospital and a lower rate of discharge home. The incidence of stroke attributable to AF increases from 1.5[1]per cent at age 50-59 years to 23.5 per cent at age 80-89 years. AF is common among UK hospital admissions being present in three to six per cent of acute medical admissions.

Many people with AF are asymptomatic and are picked up in general practice opportunistically. They may present with associated medical problems, such as heart failure, stroke or thromboembolism, and AF is detected at the same time. How long the person has had AF, and whether it was the cause or effect of the associated medical problem, may be uncertain. Stroke prevention with appropriate thromboprophylaxis is central to the management of AF[2].

AF indicator 006NI

The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous $CHADS_2$ or CHA_2DS_2-VASc score of 2 or more)

[1] ONS health statistics. 2001. Trends in mortality and hospital admissions associated with AF in England and Wales, Carroll K, Majeed A.

[2] Gregory Y H Lip, Hung-Fat Tse, Management of AF. Lancet. 2007; 370: 604-18

AF 006.1 Rationale

Guidelines recommend that people with symptomatic or asymptomatic paroxysmal, persistent or permanent AF, atrial flutter and/ or a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm should have an assessment of their stroke risk using the CHA_2DS_2-VASc risk assessment tool.

The scoring system recommended is CHA_2DS_2-VASc, which is validated and gives a score that allows a better stratification of low- risk patients than the $CHADS_2$ score[3]. There is a clinical benefit in using a stroke risk score to identify patients at risk. The review of cohort studies found that there may be a slight benefit of CHA_2DS_2-VASc over the other scores considered (CHADS2, ACCP and the ACC/AHA/ESC).

The CHA_2DS_2-VASc system further develops the CHADS2 which is based on AF Investigators I Study (AFI1) and Stroke Prevention in AF I Study (SPAF1) risk criteria[4],[5].

The CHA_2DS_2-VASc system scores one point, up to a maximum of nine, for each of the following risk factors (except previous stroke or TIA, or age ≥75 which scores double, hence the '2'):

- C: congestive HF (one point)
- H: hypertension (one point)
- A2: age 75 or over (two points)
- D: diabetes mellitus (one point)
- S2: previous stroke or TIA or thromboembolism (two points)
- V: vascular disease (e.g PAD, MI, aortic plaque) (One point)
- A: age 65-74 years (one point)
- Sc: sex category (i.e. female sex) (one point)

AF 006.2 Reporting and Verification

See indicator wording for requirement criteria.

AF 007

In those patients with atrial fibrillation whose latest record of a CHA_2DS_2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy.

[3] Gage BF, Waterman AD, Shannon E et al. Validation of clinical classification schemes for predicating stroke: results from the National Registry of AF. 2001. Journal of the Am Medical Association (AMA) 285: 2864-70

[4] Laupacis A, Boysen G, Conolly S et al. Risk factors for stroke and efficancy of anti-thrombotic therapy in AF: analysis of pooled data from five RCTs. 1994. Archives of Internal Medicine 154: 1449-57

[5] SPAF Investigators. Predictors of thromboembolism in AF: I. Clinical features pf patients at risk 1992. Annals of Internal Medicine116: 1-5

AF007.1 Rationale
This indicator aims to support the identification of people with AF who are at increased risk of stroke so that they may be offered anti-coagulation drug therapy.

Around 800,000 people in England are known to be at risk of stroke from AF. Of these, half are taking anti-coagulants and a third are currently taking aspirin. However, two-thirds of people admitted to a hospital with a stroke caused by AF are not taking recommended anti-coagulants.

Practices should not offer aspirin monotherapy solely for stroke prevention to people with AF. Evidence shows that aspirin is not as effective as anti-coagulants at preventing stroke in people with AF who are at increased risk of stroke and is also not as safe in terms of causing bleeding. Although the risks of anti-coagulation also increase with age, the evidence also shows that its benefits outweigh the risks in the vast majority of people with AF.

Stroke prevention therapy should not be offered to patients under 65 years with AF and no risk factors other than their sex (that is, very low risk of stroke equating to a CHA_2DS_2-VASc score of zero for men or one for women). Subsequent to this step, stroke prevention should be offered to those AF patients with one or more stroke risk factors.

Anti-coagulation should be offered to those patients with one or more stroke risk factors. A CHA_2DS_2-VASc score of one in women (women under age 65 with no other risk factors) should be regarded as low risk and should not receive anti-coagulation. Men with a CHA_2DS_2-VASc score of one should be regarded as at intermediate risk and a group in whom anti-coagulation should be considered.

All patients with AF and a CHA_2DS_2-VASc score of two or above should be offered anti-coagulation therapy taking their bleeding risk into account.

Anti-platelet therapy has limited benefits for patients in preventing strokes and aspirin should not be offered to patients at increased risk of stroke. Offer anti-coagulation to people with a CHA_2DS_2-VASc score of two or above, taking bleeding risk into account. Anti-coagulation may be with apixaban, dabigatran etexilate, rivaroxaban or a vitamin K antagonist.

Anti-coagulation would not necessarily be indicated if the episode of AF was an isolated event that was not expected to re-occur (for example, one-off AF with a self-limiting cause).

Guidelines considered antiplatelet therapy to have limited benefits for AF patients in preventing strokes and made a strong recommendation that aspirin should not be offered to patients at increased risk of stroke. Therefore, the AF guideline highlights the importance of offering people with AF a personalised package of care which should cover stroke awareness and measures to prevent stroke.

AF 007.2 Reporting and Verification
See indicator wording for requirement criteria.

The Business Rules will look for the latest CHA_2DS_2-VASc score in the patient record and if the score is equal to, or greater than two, the patient will be included in the denominator. If the patient does not have a CHA_2DS_2-VASc score, but does have a CHADS2 score greater than or equal to two recorded before 1 April 2016, they will be included in the denominator.

Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Achievement thresholds
Ongoing management		
CHD002. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	17	60-80%
CHD003NI. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less	17	65-75%
CHD007. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March	7	70-90%
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	70-90%

CHD – rationale for inclusion of indicator set

CHD is the single most common cause of premature death in the UK. The research evidence relating to the management of CHD is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients. This indicator set focuses on the management of patients with established CHD consistent with clinical priorities.

CHD indicator 002

The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.

CHD 002.1 Rationale
This indicator measures the intermediate health outcome of a blood pressure of 150/90 mmHg or less in patients with hypertension and CHD. Its intent is to promote the secondary prevention of cardiovascular disease (CVD) through satisfactory blood pressure control. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

Guidelines on hypertension sets blood pressure thresholds for the initiation of drug treatment of hypertension and these are outlined in the hypertension indicator set. To

summarise, patients with CHD and stage one hypertension are recommended drug therapy for hypertension.

Guidelines on hypertension recommend a target blood pressure below 140/90 mmHg in patients aged 79 or under with treated hypertension and a clinic blood pressure below 150/90 mmHg in patients aged 80 or over, with treated hypertension. For the purpose of QOF, an audit standard of 150/90 mmHg has been adopted for this indicator.

A major overview of randomised trials showed that a reduction of 5–6 mmHg in blood pressure sustained over five years reduces coronary events by 20–25 per cent in patients with CHD[6].

CHD 002.2 Reporting and verification
See indicator wording for requirement criteria.

CHD indicator 003NI

The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less.

CHD 003.1 Rationale
This indicator measures the intermediate health outcome of total cholesterol of 5 mmol/l or less in patients with established CHD. Its intent is to promote the secondary prevention of CVD. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

Clinical guidelines on lipid modification recommend that treatment for the secondary prevention of CVD is to be initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative statin preparation may be chosen.

For patients taking statins for secondary prevention, guidelines recommend that clinicians consider increasing to simvastatin 80 mg or a drug of similar efficacy and acquisition cost if either a total cholesterol of less than 4 mmol/l or a low density lipoprotein (LDL) cholesterol of less than 2 mmol/l is not attained. Any decision to offer a higher intensity statin needs to take into account informed preference, co-morbidities, multiple drug therapy and the benefit and risks of treatment. The guideline developers noted that the use of a target figure can be helpful in guiding increases of lipid lowering drugs as long as this figure is intended to guide treatment rather than be a figure patients are expected to achieve.

Clinical Guidelines on lipid modification recommends that an 'audit' level of total cholesterol of 5 mmol/l is used to assess progress in populations or groups of people with CVD. The guidance here is given in terms of total cholesterol.

[6] Collins et al. Lancet 1990; 335: 827-38

CHD 003.2 Reporting and verification
See indicator wording for requirement criteria.

CHD indicator 007

The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March

CHD 007.1 Rationale
This is a current recommendation from the Chief Medical Officer (CMO) and the Joint Committee on Vaccination and Immunisation (JCVI).

CHD 007.2 Reporting and verification
See indicator wording for requirement criteria.

CHD indicator 005

The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.

CHD 005.1 Rationale
Clinical guidelines recommend that aspirin (75 – 150 mg per day) is given routinely and continued for life in all patients with CHD unless there is a contraindication. Clopidogrel (75 mg/day) is an effective alternative in patients with contraindications to aspirin, or who are intolerant of aspirin. Aspirin should be avoided in patients who are anti-coagulated.

CHD 005.2 Reporting and verification
See indicator wording for requirement criteria.

Heart failure (HF)

Indicator	Points	Achievement thresholds
Initial diagnosis		
HF002NI. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 15 months after entering on to the register	6	70–90%
Ongoing management		
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	10	65-80%
HF004. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure	9	40–65%

HF – rationale for inclusion of indicator set

HF represents the only major cardiovascular disease with increasing prevalence and is responsible for dramatic impairment of quality of life, carries a poor prognosis for patients and is very costly for the NHS to treat (second only to stroke). This indicator set refers to all patients with HF unless specified otherwise.

HF indicator 002NI

The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 15 months after entering on to the register.

HF 002.1 Rationale
This indicator requires that all patients with suspected HF are investigated[7] and this is expected to involve, as a minimum, further specialist investigation (such as echocardiography) and often specialist opinion. Serum natriuretic peptides can be used to determine whether patients with clinically suspected HF need a referral for echocardiography and their use is recommended as below. Specialists may include GPs identified by the Regional Board as having a special interest in HF. Many HF patients will be

[7] Senni et al. J Am College of Cardiology. 1999; 33(1): 164-70; NICE clinical guideline CG108. http://www.nice.org.uk/CG108/niceguidance/pdf/english

diagnosed following specialist referral or during hospital admission and some will also have their diagnosis confirmed by tests such as cardiac scintography or angiography rather than echocardiography.

Current guidelines recommend that patients with suspected HF receive both echocardiography and specialist assessment. The guidance also recommends that serum natriuretic peptides are measured in patients with suspected HF without previous MI. Patients with suspected HF who have had a previous MI or who have very high levels of serum natriuretic peptide are considered to require urgent referral due to their poor prognosis. Clinical guidelines on the management of chronic HF recommends that echocardiography is performed in patients with suspected HF who have either a raised serum natriuretic peptide or abnormal electrocardiograph result to confirm the diagnosis and establish the underlying cause.

HF 002.2 Reporting and verification
See indicator wording for requirement criteria.

HF indicator 003

In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB

HF 003.1 Rationale

There is strong clinical and cost-effectiveness evidence to support the use of ACE-I in all patients with HF with LVSD. ACE-I improve symptoms, reduce the hospitalisation rate and improve the survival rate. This is applicable in all age groups. ARBs are also effective in the treatment of patients with HF due to LVSD, but may only be used in patients intolerant of ACE-I.

It is possible to have a diagnosis of LVSD without HF, for example, asymptomatic people who might be identified coincidently but who are at high risk of developing subsequent HF. In such cases, ACE-I's delay the onset of symptomatic HF, reduce cardiovascular events and improve long-term survival. This indicator only applies to patients with HF and therefore excludes this other group of patients who are nevertheless to be considered for treatment with ACE-I.

Clinical Guidelines recommend that ACE-I is used as first-line therapy in all patients with HF due to LVSD and that ARBs are used only in patients who are intolerant of ACE-I.

HF 003.2 Reporting and verification
See indicator wording for requirement criteria.

HF indicator 004

In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure.

HF 004.1 Rationale

The evidence base for treating HF due to LVSD with beta blockers[8,9] is at least as strong as the evidence base guiding the HF004 indicator on ACE-I (level 1a), with a 34 per cent reduction in major endpoints of beta-blockers on top of ACE-I compared to placebo and is a standard recommendation in all HF guidelines. The belief that beta-blockers are contraindicated in HF was disproved, at least for the licensed beta-blockers, in the late 1990s and in some countries (especially in Scandinavia) beta-blockers have never been contraindicated in HF. Furthermore, there are no data to suggest excess risk in the elderly (SENIORS with nebivolol only randomised patients aged over 70 with significant benefits and no safety signal) and there are no contraindications for use in patients with COPD.

However, despite the evidence above, initiating beta-blockers in HF, or switching from one not licensed for HF, is more difficult because of the need to titrate from low doses and small increments over repeated visits. Patients also often suffer a temporary deterioration in symptoms with beta-blocker initiation which needs monitoring.

The British National Formulary (BNF) states that "the beta-blockers bisoprolol and carvedilol are of value in any grade of stable HF and LVSD; nebivolol is licensed for stable mild to moderate HF in patients aged over 70, beta-blocker treatment should be initiated at a very low dose and titrated very slowly over a period of weeks or months by those experienced in the management of HF. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy"[10].

Clinical Guidelines recommend that beta-blockers licensed for HF are used as first-line therapy in all patients with HF due to LVSD. CG108 recommends that beta-blockers are used in patients with defined co-morbidities such as older adults and those with peripheral vascular disease (PVD), erectile dysfunction (ED), DM, interstitial pulmonary disease and COPD without reversibility. The only co-morbidities with a clear contra-indication to beta-blocker use are those with asthma and reversible airways obstruction (these groups were excluded from clinical trials).

Contractors are advised that patients already prescribed an unlicensed beta-blocker prior to diagnosis of HF due to LVSD do not have their drug therapy changed to meet the criteria of this indicator. Those patients already prescribed an unlicensed beta-blocker will be excluded.

HF 004.2 Reporting and verification

See indicator wording for requirement criteria.

Patients already prescribed a beta-blocker unlicensed for heart failure will be excluded from this indicator.

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[8] Deedwania PC, Giles TD, Klibaner M, Ghali JK, Herlitz J, Hildebrant P, Kjekshus J, Spinar J, Vitovec J, Stanbrook H, Wikstrand J, MERIT-HF study group. Efficacy, safety and tolerability of metoprolol CR/XL in patients with DM and chronic HF: experiences from MERIT-HF. Am Heart Journal. 2005; 49(1): 159-67

[9] CIBIS-II Investigators and Committees. Cardiac Insufficiency Bisoprolol Study II. Lancet 1999; 353:9-13

[10] BNF. http://bnf.org/bnf/bnf/current/119651.htm (password protected site)

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Ongoing management		
HYP002NI. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	20	65-80%

HYP – rationale for inclusion of indicator set

Hypertension is a common medical condition which is largely managed in primary care and represents a significant workload for GPs and the primary care team. Trials of anti-hypertensive treatment have confirmed a significant reduction in the incidence of stroke and CHD in patients with treated hypertension.

HYP indicator 002NI

The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.

HYP 002.1 Rationale
This indicator measures the intermediate health outcome of a blood pressure of 150/90 mmHg or less in patients with hypertension. Its intent is to promote the primary and secondary prevention of CVD through satisfactory blood pressure control. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

Clinical guidelines on hypertension recommend drug therapy in patients who are aged 79 or under with stage 1 hypertension who have one or more of the following:

1. target organ damage
2. established CVD
3. renal disease
4. diabetes mellitus
5. a 10-year CVD risk equivalent to 20 per cent or greater.

Guidelines recommend anti-hypertensive drug treatment for patients of any age with stage 2 hypertension.

The guideline recommends that a referral for specialist evaluation of secondary causes of hypertension and a more detailed assessment of potential target organ damage is

considered for patients aged 39 or under with stage 1 hypertension and no evidence of target organ damage, CVD, renal disease or diabetes. This is because 10-year cardiovascular risk assessments can underestimate the lifetime risk of cardiovascular events in these patients.

The guideline also recommends that patients with hypertension have their care reviewed annually to monitor blood pressure, provide support and discuss lifestyle, symptoms and medication. However, the frequency of follow-up depends on factors such as the severity of hypertension, variability of blood pressure, complexity of the treatment regime, patient compliance and the need for non-pharmacological advice.

For QOF purposes it is assumed that repeat blood pressure measurements are undertaken every six months, with the audit standard at nine months.

HYP 002.2 Reporting and verification
See indicator wording for requirement criteria.

Stroke and TIA (STIA)

Indicator	Points	Achievement thresholds
Initial diagnosis		
STIA008NI The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2016) who have a record of a referral for further investigation between 3 months before and 1 month after the date of the latest recorded stroke or the first TIA	2	65–80%
Ongoing management		
STIA003. The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15months) is 150/90 mmHg or less	5	60-80%
STIA004NI. The percentage of patients with stroke and is shown to be non-haemorrhagic or a history of TIA who have a record of total cholesterol in the preceding 3 years	2	50–90%
STIA005NI. The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less	5	60-70%
STIA009. The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March	2	65-90%
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken	4	70-90%

STIA – rationale for inclusion of indicator set

Stroke is the third most common cause of death in the developed world. One quarter of stroke deaths occur under the age of 65. There is evidence that appropriate diagnosis and management can improve outcomes.

STIA indicator 008NI

The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2016) who have a record of a referral for further investigation between 3 months before and 1 month after the date of the latest recorded stroke or the first TIA.

STIA 008.1 Rationale
Specialist investigations are often only accessible by a referral to secondary care services, therefore this indicator reflects referral activity rather than confirmation by specific scanning investigations.

The National Audit Office (NAO) report[11] highlights that UK national guidelines recommend that all patients with suspected TIA are assessed and investigated within seven days, but notes that only a third of patients with TIA are seen in a clinic. The UK guideline and the NAO concern reflect the evidence that there is a high early risk of stroke following TIA and that there is insufficient recognition of the serious nature of this diagnosis.

Contractors are advised that a referral should be considered for each new stroke or TIA unless specific agreement has been reached with a local specialist not to refer the patients. It is recommended that a new TIA in someone who has had previous TIAs is treated as an urgent case.

For the purposes of QOF, an appropriate referral being undertaken between three months before or one month after a diagnosis of presumptive stroke or TIA being made, would be considered as having met the requirements of this indicator.

STIA 008.2 Reporting and verification
See indicator wording for requirement criteria.

STIA indicator 003

The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less.

STIA 003.1 Rationale
This indicator measures the intermediate health outcome of a blood pressure of 150/90 mmHg or less in patients with hypertension and CHD. Its intent is to promote the secondary prevention of CVD through satisfactory blood pressure control. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

In one major overview, a long-term difference of 5-6 mmHg in usual diastolic blood pressure (DBP) is associated with approximately 30–40 per cent less stroke over five years[12]. The PROGRESS trial demonstrated that blood pressure lowering reduces stroke risk in patients with prior stroke or TIA[13].

Clinical Guidelines on hypertension set blood pressure thresholds for the initiation of drug treatment of hypertension and these are outlined in the rationale for the hypertension indicator set. To summarise, all patients aged 79 or under with CVD and stage one

[11] NAO report. The stationary office. Reducing brain damage: faster access to better stroke care 2005. http://www.nao.org.uk/publications/0506/reducing_brain_damage.aspx
[12] Collins et al. Lancet 1990; 335:827-38
[13] PROGRESS collaborative group, Lancet 2001: 358: 1033-41

hypertension (clinic blood pressure is 140/90 mmHg or higher and subsequent ABPM daytime average of HBPM average blood pressure is 135/85 mmHg or higher) are recommended drug therapy for hypertension.

Clinical guidelines on the management of patients with stroke or TIA recommend that patients who have had a stroke or TIA and have hypertension are treated to less than 140/85 mmHg.

Clinical guidelines on hypertension recommend a target clinic blood pressure below 140/90 mmHg in patients aged 79 or under with treated hypertension and a clinic blood pressure below 150/90 mmHg in patients aged 80 or over, with treated hypertension.

For the purpose of QOF, an audit standard of 150/90 mmHg has been adopted.

Further information
RCP stroke guideline 2008. http://bookshop.rcplondon.ac.uk/details.aspx?e=250

STIA 003.2 Reporting and verification
See indicator wording for requirement criteria.

STIA indicator 004NI

The percentage of patients with stroke and is shown to be non-haemorrhagic or TIA who have a record of total cholesterol in the preceding 3 years.

STIA 004.1 Rationale
Clinical guidelines on lipid modification recommend statin therapy for patients with clinical evidence of CVD. The guideline recommends that the decision on whether to initiate statin therapy is made after an informed discussion between the responsible clinician and the patient about the risks and benefits of statin treatment, taking into account additional factors such as co-morbidities and life expectancy.

Clinical guidelines on chronic HF recommend that treatment for the secondary prevention of CVD is initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative statin preparation may be chosen.

For patients taking statins for secondary prevention, guidelines recommend that clinicians consider increasing to simvastatin 80 mg or a drug of similar efficacy and acquisition cost if a total cholesterol of less than 4 mmol/l or an LDL cholesterol of less than 2 mmol/l is not attained. It is advised that any decision to offer a higher intensity statin takes into account informed preference, co-morbidities, multiple drug therapy and the benefit and risks of treatment.

Clinical guidelines state that statin therapy after haemorrhagic stroke is not routinely recommended unless the risk of further vascular events outweighs the risk of further haemorrhage.

The RCP stroke guideline[14] states that treatment with statin therapy be avoided or used with caution (if required for other indications) in individuals with a history of haemorrhagic stroke, particularly those with inadequately controlled hypertension.

STIA 004.2 Reporting and verification
See indicator wording for requirement criteria.

STIA indicator 005NI

The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less.

STIA 005.1 Rationale
This indicator measures the intermediate health outcome of total cholesterol of 5 mmol/l or less in patients with established stroke or TIA (cerebrovascular disease, one of the main causes of CVD) and its intent is to promote the secondary prevention of CVD. This intermediate outcome can be achieved through lifestyle advice and the use of drug therapy.

In April 2013 this indicator was updated to reflect the findings of a systematic review[15] on the effectiveness of statins in people with ischaemic and haemorrhagic stroke. The review concluded that there is evidence that statin therapy in patients with a history of ischaemic stroke or TIA significantly reduces subsequent major coronary events but only marginally reduces the risk of stroke recurrence.

However, analysis by type of subsequent stroke (two RCTs: Heart Protection Study and SPARCL) showed evidence for a protective effect of statins for ischaemic stroke (OR 0.78, 95 per cent CI 0.67 to 0.92) but evidence for an increased risk of haemorrhagic stroke (OR 1.72, 95 per cent CI 1.20 to 2.46). It is also noted that there is no national or international consensus on whether statins be used for all types of stroke. For these reasons, the population of the indicator includes people who have had ischaemic stroke or history of TIA.

Clinical guidelines on lipid modification, recommend statin therapy for patients with clinical evidence of cerebrovascular disease. The guideline recommends that the decision on whether to start statin therapy is made after discussion between the clinician and patient about the risks and benefits of statin treatment, taking into account additional factors such as co-morbidities and life expectancy.

Guidelines recommend that treatment for secondary prevention of cerebrovascular disease be initiated with simvastatin 40 mg. If there are potential drug interactions, or if simvastatin 40 mg is contraindicated, a lower dose or alternative statin preparation may be chosen.

[14] RCP stroke guideline 2008. http://bookshop.rcplondon.ac.uk/details.aspx?e=250
[15] Cochrane review, Manketlow BN, Potter JF, 2009.

For patients taking statins for secondary prevention, guidelines recommend that clinicians consider increasing dosage of simvastatin to 80 mg or a drug of similar efficacy and acquisition cost, if total cholesterol of less than 4 mmol/l or LDL cholesterol of less than 2 mmol/l, is not attained. It is advised that any decision to offer a higher intensity statin takes into account informed preference, co-morbidities, multiple drug therapy and the benefit and risks of treatment.

Clinical Guidelines on the management of patients with stroke or TIA, state that a statin is prescribed to patients who have had ischaemic stroke, irrespective of cholesterol level. However, the use of statin after haemorrhagic stroke is not routinely recommended unless the risk of further vascular events outweighs the risk of further haemorrhage.

The RCP clinical guideline on stroke[16], states that all patients who have had ischaemic stroke or TIA are treated with a statin drug unless contraindicated. However, treatment with statin therapy be avoided or used with caution (if required for other indications) in individuals with a history of haemorrhagic stroke, particularly those with inadequately controlled hypertension.

Guidelines recommend that an audit level of total cholesterol of 5 mmol/l be used to assess progress in patients with CVD.

STIA 005.2 Reporting and verification
See indicator wording for requirement criteria.

STIA indicator 009

The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March.

STIA 009.1 Rationale
While there have been no RCTs looking at the impact of flu vaccination specifically in patients with a history of stroke or TIA, there is evidence from observation studies that flu vaccination reduces risk of stroke[17].

This is a current recommendation from the CMO and the JCVI.

STIA 009.2 Reporting and verification
See indicator wording for requirement criteria.

[16] RCP clinical guideline. Stroke 2008. http://bookshop.rcplondon.ac.uk/details.aspx?e=250
[17] Lavallee et al. Stroke 2002; 33: 513-518; Nichol et al. *NEJM* 2003; 1322-32

STIA indicator 007

The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken.

STIA 007.1 Rationale
Long-term anti-platelet therapy reduces the risk of serious vascular events following a stroke by about a quarter. It is advised that anti-platelet therapy is prescribed for the secondary prevention of recurrent stroke and other vascular events in patients who have sustained an ischaemic cerebrovascular event.

The BNF[18] makes the following recommendations:

"Following a TIA, long-term treatment with modified-release dipyridamole 200 mg twice daily in combination with aspirin 75 mg once daily is recommended. If patients are intolerant of aspirin, or it is contra-indicated, then modified-release dipyridamole alone is recommended. If patients are intolerant of dipyridamole, or it is contraindicated, then aspirin alone is recommended. Patients who are intolerant of both aspirin and dipyridamole should receive clopidogrel alone [unlicensed use].

Following an ischaemic stroke (not associated with AF – see below), long-term treatment with clopidogrel 75 mg once daily is recommended. If clopidogrel is contraindicated or not tolerated, patients should received modified-release dipyridamole 200 mg twice daily in combination with aspirin 75 mg once daily. If both aspirin and clopidogrel are contraindicated or not tolerated, then modified-release dipyridamole alone is recommended. If both dipyridamole and clopidogrel are contraindicated or not tolerated, than aspirin alone is recommended."

It is advised that patients with stroke associated with AF are reviewed for long-term treatment with warfarin or an alternative anti-coagulant (see the AF disease area indicator set).

STIA 007.2 Reporting and verification
See indicator wording for requirement criteria.

[18] BNF 62.http://bnf.org/bnf/index.htm

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Ongoing management		
DM002NI. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	8	65-75%
DM003NI. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15months) is 140/80 mmHg or less	10	40-65%
DM004NI. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 15 months) is 5 mmol/l or less	6	60-80%
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	65-80%
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months	17	40-50%
DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months	8	55-70%
DM009. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months	10	50-90%
DM010. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	65-90%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months	4	50–90%

DM015NI. The percentage of male patients with diabetes, on the register, with whom erectile dysfunction has been discussed. Where appropriate patients should have been offered advice/investigation/treatment.	4	40–90%

DM – rationale for inclusion of indicator set

Diabetes mellitus (DM) is one of the common endocrine diseases affecting all age groups with over one million people in the UK having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with type 2 diabetes, is undertaken by the GP and members of the primary care team.

The indicators for diabetes are based on widely recognised approaches to the care of diabetes.

The website contains detailed evidence tables, and links to published articles. The English National Service Framework (NSF) for Diabetes website[19] also includes details of the evidence behind a range of recommendations.

Guidance has been published on a number of aspects of diabetic control.

Further information
The indicators for diabetes are generally those which would be expected to be done, or checked, in an annual review. There is no requirement for the contractor to carry out all of these items (e.g. retinal screening) but it is the contractor's responsibility to ensure that they have been done.

DM indicator 002NI

The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months)is 150/90 mmHg or less.

DM 002.1 Rationale
Blood pressure lowering in patients with diabetes reduces the risk of macrovascular and microvascular disease.

DM003 sets a target of 140/80 mmHg as per the target recommended by guidance while the target of 150/90 mmHg has been set for those patients who cannot manage this, such as those with retinopathy, micro-albuminuria or cerebrovascular disease.

Setting a blood pressure target at a higher level, but expecting most patients to have blood pressure below this, is intended to encourage practitioners to address the needs of the minority of patients whose blood pressure is hard to control and will avoid the possibility of perverse incentives to focus efforts away from those at highest absolute risk.

[19] DH. www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en

DM 002.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 003NI

The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less

DM 003.1 Rationale
Blood pressure lowering in patients with diabetes reduces the risk of macrovascular and microvascular disease.

The target of 140/80 mmHg has been set as per the target.

DM 003.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 004NI

The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 15 months) is 5 mmol/l or less.

DM 004.1 Rationale
It is advised that statin therapy to reduce cholesterol is initiated and titrated as necessary to reduce total cholesterol to less than 5 mmol/l. There is ongoing debate concerning the intervention levels of serum cholesterol in diabetic patients who do not apparently have CVD.

Glinical guidelines on type 2 diabetes - newer agents recommends initiating lipid lowering therapy in all patients with type 2 diabetes aged over 40 and for patients aged 39 or under recommends initiating drug therapy in patients with type 2 diabetes who have a poor cardiovascular risk factor profile.

Clinical guidelines on the management of diabetes recommends lipid lowering drug therapy for primary prevention in patients with type 2 diabetes aged 40 or over irrespective of baseline cholesterol. For patients with type 1 diabetes guidelines recommend lipid lowering drug therapy for patients aged 40 or over and for patients aged 39 or under with both type 1 and type 2 diabetes, recommends considering lipid lowering drug therapy.

Further information
Heart Protection Study Collaborative Group. MRC/BHF heart protection study of cholesterol-lowering with simvastatin in 5963 people with diabetes: a randomised placebo-controlled trial[20].

[20] Lancet 2003; 361: 2005-2016

Mortality from CHD in subjects with type 2 Diabetes and in non-diabetic subjects with and without Prior MI. Haffner et al[21].

DM 004.2 Reporting and verification
See indicator wording for requirement criteria.

The contractor would be expected to explore fully with their ICP whether or not a suitable investigative or secondary service could be commissioned for the patient prior to deciding to accept them on the basis that the services was unavailable.

DM indicator 006

The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs).

DM 006.1 Rationale
The progression of renal disease in patients with diabetes is slowed by treatment with ACE-I and trial evidence suggests that these are most effective when given in the maximum dose quoted in the BNF. Although trial evidence is based largely on ACE-I, it is believed that similar benefits occur from treatment with ARBs in patients who are intolerant of ACE-I.

It is recommended that patients with a diagnosis of micro-albuminuria or proteinuria are commenced on an ACE-I or considered for treatment with ARBs.

DM 006.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 007

The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months.

DM 007.1 Rationale
The three target levels for HbA1c (59, 64 and 75 mmol/mol) in QOF are designed to provide an incentive to improve glycaemic control across the distribution of HbA1c values. The lower level may not be achievable or appropriate for all patients. Clinical guidelines on the management of type 2 diabetes advises against pursuing highly intensive management to levels below 48 mmol/mol in certain patient sub-groups.

There is a near linear relationship between glycaemic control and death rate in patients with type 2 diabetes[22]. In the EPIC Norfolk population cohort, a one per cent higher HbA1c was independently associated with 28 per cent higher risk of death, an association that extended below the diagnostic cut off for diabetes. These results suggest that, as with

[21] NEJM 1998; 339: 229-234
[22] Khaw KT, Wareham N, Luben R et al. Glycated haemoglobin, diabetes, and mortality in men in Norfolk cohort of Euro prospective investigation of cancer and nutrition (EPIC-Norfolk) 2001. BMJ; 322: 15-18

blood pressure and cholesterol, over the longer term at least, the lower the HbA1c the better[23].

However, the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial highlighted the risks of adopting an aggressive treatment strategy for patients at risk of CVD. In the trial's intervention group, HbA1c fell from 8.1 per cent to 6.4 per cent, but this was associated with increased mortality[24]. However, a recent meta-analysis did not confirm such an increase in risk[25] and reassuringly, the ADVANCE study[26] and the Veteran Affairs Diabetes Trial[27] found no increase in all-cause mortality in their intensive treatment groups. Also, long-term follow up of the UK Prospective Diabetes Study demonstrated a 'legacy effect' with fewer deaths after ten years in those initially managed intensively[28].

A retrospective analysis of cohort data from the UK General Practice Research Database (GPRD) has reopened the debate about how low to aim[29]. The study found that, among people whose treatment had been intensified by the addition of insulin or a sulphonylurea, there was no benefit in reducing HbA1c below 59 mmol/mol, although these differences were not statistically significant. The mortality rate was higher among those with the tightest control (this lowest decile of cohort had HbA1c below 6.7 per cent; median = 6.4 per cent). The reasons for these findings are unclear, but they raise further questions about the possibility of some groups of patients for whom a tight glycaemic target is inappropriate.

Clinical Guidelines on type 2 diabetes identifies the following key priorities for implementation to help people with type 2 diabetes achieve better glycaemic control:

- Offer structured education to every patient and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform patients and their carers that structured education is an integral part of diabetes care.

- Provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition.

- When setting a target HbA1c:

    1. involve the patient in decisions about their individual HbA1c target level, which may be above that of 48 mmol/mol set for people with type 2 diabetes in general.

[23] Elley CR, Kenealy T, Robinson E et al. Glycated haemoglobin and cardiovascular outcomes in people with type 2 diabetes: a large prospective cohort study. Diabetic medicine 2008; 25: 1295-1301
[24] ACCORD Study Group. Effects of intensive glucose lowering in type 2 diabetes 2008. NEJM; 358: 2545-59
[25] Ray KK, Seshasai SR, Wijesuriya S et al. Effect of intensive control of glucose on cardiovascular outcomes and death in patients with DM: a meta-analysis of RCTs 2009. Lancet; 373: 1765-72
[26] ADVANCE collaborative group. Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. NEJM 2008; 358: 2560-72
[27] Duckworth W, Abraira C, Moritz T et al. Glucose control and vascular complications in veterans with type 2 diabetes 2009. NEJM; 360: 129-39
[28] Holman RR, Paul SK, Bethel MA et al. 10-year follow-up of intensive glucose control in type 2 diabetes 2008. NEJM; 359: 1577-89
[29] Currie CJ, Peters JR, Tynan A, et al. Survival as a function of HbA1c in people with type 2 diabetes: a retrospective cohort study 2010. The Lancet; 375: 481-9

2. encourage the patient to maintain their individual target unless the resulting side effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life.

3. offer therapy (lifestyle and medication) to help achieve and maintain the HbA1c target level.

4. inform a patient with higher HbA1c that reduction in HbA1c towards the agreed target is advantageous to future health.

5. avoid pursuing highly intensive management to levels of less than 48 mmol/mol.

Given that there is strong evidence to support tight glycaemic control in type 1 diabetes, which is reflected in current guidelines, this indicator aims to balance risks and benefits for patients with type 2 diabetes. Younger patients with little co-morbidity are more likely to reap the benefits of tighter control, whereas less stringent goals may be more appropriate for patients with established CVD, those with a history of hypoglycaemia, or those requiring multiple medications or insulin to achieve a suggested target HbA1c of 48 mmol/mol.

From June 2009 the way in which HbA1c results are reported in the UK changed. A standard specific for HbA1c was prepared by the IFCC so that HbA1c reported by laboratories is traceable to the IFCC reference method and global comparison of HbA1c results is possible. From 1 June 2011, results were reported only as IFCC-HbA1c mmol/mol (see table one below).

Table 1. IFCC values expressed as mmol/mol

DCCT values for HbA1c (%)	IFCC values for HbA1c (mmol/mol)
4.0	20
5.0	31
6.0	42
6.5	48
7.0	53
7.5	59
8.0	64
9.0	75
10.0	86
11.0	97
12.0	108

DM 007.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 008

The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months.

DM 008.1 Rationale
See DM 007.1

Auditing the proportion of patients with an HbA1c below 64 mmol/mol is designed to provide an incentive to improve glycaemic control across the range of HbA1c values.

DM 008.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 009

The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months.

DM 009.1 Rationale
See DM 007.1.

Auditing the proportion of patients with an HbA1c below 75 mmol/mol is designed to provide an incentive to improve glycaemic control amongst those with high levels of HbA1c who are at particular risk.

DM 009.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 010

The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March.

DM 010.1 Rationale
This is a current recommendation from the CMO and the JCVI.

DM 010.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 012

The percentage of patients with diabetes, on the register, with a record of foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.

DM 012.1 Rationale
Patients with diabetes are at high risk of foot complications. Evaluation of skin, soft tissue, musculoskeletal, vascular and neurological condition on an annual basis is important for the detection of feet at raised risk of ulceration.

The foot inspection and assessment includes:

- identifying the presence of sensory neuropathy (loss of ability to feel a monofilament, vibration or sharp touch) and/or the abnormal build-up of callus;
- identifying when the arterial supply to the foot is reduced (absent foot pulses, signs of tissue ischaemia or symptoms of intermittent claudication);
- identifying deformities or problems of the foot (including bony deformities , dry skin or fungal infection), which may put it at risk;
- identifying other factors that may put the foot at risk (which may include reduced capacity for self-care, impaired renal function, poor glycaemic control, cardiovascular and cerebrovascular disease, or previous amputation).

Clinical guideline on type 2 diabetes advises that foot risk is classified as:

- at low current risk: normal sensation, palpable pulses;
- at increased risk: neuropathy or absent pulses or other risk factor;
- at high risk: neuropathy or absent pulses plus deformity or skin changes or previous ulcer;
- ulcerated foot.

The practitioner carrying out the inspection and assessment is advised to:

- discuss with the patient their individual level of risk and agree plans for future surveillance;
- initiate appropriate referrals for expert review of those with increased risk;
- give advice on action to be taken in the event of a new ulcer/lesion arising;
- give advice on the use of footwear which will reduce the risk of a new ulcer/lesion;
- give advice on other aspects of foot care which will reduce the risk of a new ulcer/lesion.

For the purposes of QOF the Read codes for 'moderate risk' are used to record the concept of 'increased risk'.

DM 012.2 Reporting and verification
See indicator wording for requirement criteria.

DM indicator 015NI

The percentage of male patients with diabetes, on the register, with whom erectile dysfunction has been discussed. Where appropriate, patients should have been offered advice/investigation/treatment.

DM 015.1 Rationale
Erectile dysfunction (ED) is a manifestation of autonomic neuropathy as a complication of long-term hyperglycaemia and as such is a common complication of diabetes. Reported prevalence in men with diabetes ranges from 35-90 per cent, depending upon the study methodology and population characteristics. In the Massachusetts Male Aging Study[30], the age-adjusted probability of complete ED was three times greater in men with type 2 diabetes than in those without.
ED is a traumatic complication for some men with diabetes. Although a benign disorder that is not perceived as life-threatening, it can have a significant impact on the quality of life for men with diabetes, their partners and families.

Clinical guidelines on type 2 diabetes, recommends that all men with diabetes are asked about ED on an annual basis, irrespective of age.

The issue of ED can be a difficult topic for both patients and healthcare professionals. It is important that it is discussed in a sensitive manner which allows patients to voice their concerns in a safe and supportive environment. Contractors may wish to consider who in the practice team is best placed to address this issue with patients, how to discuss the issue and whether or not to integrate it into the diabetes annual review.

Nurses who feel uncomfortable addressing sexual health issues with patients may wish to follow the Royal College of Nursing's (RCN) guidance on sexuality and sexual health in nursing practice[31].

DM 015.2 Reporting and verification
See indicator wording for requirement criteria.

[30] Feldman HA, Goldstein I, Hatzichristou DG, et al. Impotence and its medical and psychosocial correlates: results of the Massachusetts Male Aging Study 1994. Journal of Urology 151(1): 54-61
[31] RCN guidance on sexuality and sexual health in nursing practice.
http://www.rcn.org.uk/newsevents/news/article/uk/rcn_launches_new_sexual_health_skills_framework

Asthma (AST)

Indicator	Points	Achievement thresholds
Initial diagnosis		
AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis	15	45–80%
Ongoing management		
AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions	20	45–70%
AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months	6	45–80%

AST – rationale for inclusion of indicator set

Asthma is a common condition which responds well to appropriate management and which is principally managed in primary care.

AST indicator 002

The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis.

AST 002.1 Rationale
There is no single infallible test to confirm a diagnosis of asthma. On the basis of the clinical history and examination it will be possible to decide if the probability of asthma is high, intermediate or low and the aim of investigations is to demonstrate objectively the presence of variability in order to support or reject the diagnosis. There are Read codes for 'suspected asthma' and 'suspected respiratory condition' which may be used whilst investigations are undertaken and the diagnosis confirmed.

Further information about the diagnosis of asthma is provided in the asthma clinical guidelines. It is crucial that diagnostic spirometry is performed to published quality standards[32].

Asthma history

The diagnosis of asthma is suspected when a patient presents a history of variable wheeze, chest tightness, shortness of breath or cough, commonly triggered by viral infections and/or allergy and/or exercise. A personal or family history of atopy (including positive skin prick testing) increases the probability of asthma.

If asthma is probable

In symptomatic patients airway obstruction may be demonstrated by spirometry (FEV_1/FVC ratio <0.7) and (if available) nitric oxide can be used to measure airway inflammation.

Variability of symptoms and/or lung function may be demonstrated in a reversibility test or may occur spontaneously over time in response to triggers or to treatment; demonstration of variability supports the diagnosis of asthma and may be conveniently achieved in primary care in a number of ways:

- Spirometry may be used to demonstrate reversibility in symptomatic patients with demonstrated airflow obstruction. A bronchodilator reversibility test can be performed with inhaled or nebulised short acting beta agonist and if the obstruction reverses then asthma is confirmed. Significant reversibility is a change in FEV_1 >12 per cent and 200 ml (the absolute change is scaled down according to predicted FEV_1 in children). Increases of >400 mls are strongly suggestive of asthma. Lower levels of bronchodilator reversibility may be demonstrated in some patients with COPD. Normal spirometry, however, does not exclude asthma; indeed the variable nature of asthma means that many of the milder patients seen in primary care will be asymptomatic at the time of the lung function test and will have completely normal lung function with no reversibility at the time of testing.

- Variability of PEF. This may be demonstrated by monitoring diurnal, or day to day variation (recorded twice a day for two weeks using the same peak flow meter) and/or demonstrating an increase after therapy (15 minutes after short-acting bronchodilator, after six weeks of inhaled steroids, or up to two weeks after oral steroid treatment) and/or after exposure to triggers (such as exercise, laughter, or allergens). Significant variability is a change of 20 per cent and >60 l/min (the absolute change is scaled down in children to 20 per cent of predicted PEF). PEF are effort dependent and patients need to be taught the correct technique.

- Variability in objective measures of asthma symptom scores (e.g. RCP questions[33], ACQ[34], ACT questionnaire[35], or GINA Control Tool[36]). Symptom scores may be

[32] Levy ML, Quanjer PH, Booker R, Cooper BG, Holmes S, Small I. Diagnostic spirometry in primary care: Proposed standards for general practice compliant with ATS and Euro Respiratory Society recommendations: a General Practice Airways Group document in association with the Association for Respiratory Technology & Physiology and Education for Health. PCRJ 2009; 18:130-47. http://dx.doi.org/10.4104/pcrj.2009.00054

[33] Pearson MG, Bucknall CE, editors. Measuring clinical outcome in asthma: a patient-focused approach. RCP 1999.

particularly useful in patients unable to undertake accurate serial measures of lung function and to aid clinical interpretation of lung function (e.g. normal lung function in a symptomatic patient might suggest an alternative cause for the symptoms).

A trial of treatment, with repeated lung function measurements and/or symptoms scores over time will demonstrate objective improvement of symptoms and lung function in people with asthma, thereby confirming the diagnosis. In children it is particularly important to reduce and stop treatment to exclude spontaneous improvement[37].

If the probability of asthma is intermediate
Spirometry is the key investigation for distinguishing obstructive and restrictive respiratory conditions and will determine subsequent investigations. More specialist assessment may be required in those in whom the diagnosis is still unclear, which may include assessment of airway inflammation (e.g. nitric oxide measurement), bronchial hyper-responsiveness testing and consideration of alternative diagnoses. It is recommended that children with combined food allergy and asthma and any patient with late onset asthma where there is a suspicion of an occupational cause are referred for specialist assessment.

If another diagnosis is more likely
If an alternative diagnosis is suspected, investigation and management are to follow guidelines for that condition.

Co-morbidity: asthma and COPD
A proportion of patients with asthma will have both asthma and COPD e.g. they have airway obstruction that does not reverse to normal but also have substantial reversibility[38].

AST 002.2 reporting and verification
See indicator wording for requirement criteria.

AST indicator 003

The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions

AST 003.1 Rationale
Structured care has been shown to produce benefits for patients with asthma. The reckoning of morbidity, PEF levels, inhaler technique and current treatment and the promotion of self-management skills are common themes of good structured care. Clinical

[34] Juniper EF, O'Byrne PM, Guyatt GH, Ferrie PJ, King DR. Development and validation of a questionnaire to measure asthma control. Euro Respiratory Journal 1999;14:902-7
[35] Nathan RA, Sorkness CA, Kosinski M, et al. Development of the asthma control test: a survey for assessing asthma control. Journal of Allergy Clinical Immunology 2004;113:59-65
[36] GINA. The Global Strategy for Asthma Management and Prevention 2011. http://www.ginasthma.org
[37] Brand P. New guidelines on recurrent wheeze in preschool children: implications for primary care. PCRJ 2008; 17:243-245
[38] NICE clinical guideline CG101. The management of COPD in adults in primary and secondary care. Thorax 2004;59 (Suppl1):S1–23.

guidelines propose a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

Clinical guidelines recommend the use of standard questions for the monitoring of asthma. Proactive structured review, rather than opportunistic or unscheduled review, is associated with reduced exacerbation rate and fewer days lost from normal activity.

The QOF now explicitly requires that the following RCP questions[39] are used as an effective way of assessing symptoms:

In the last month:

- Have you had difficulty sleeping because of your asthma symptoms (including cough)?
- Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?
- Has your asthma interfered with your usual activities (for example, housework, work/school, etc.)?

The questions are to be asked at the same time and as part of the review. A response of 'No' to all questions is consistent with well-controlled asthma[40].

If the asthma appears to be uncontrolled, the following are to be managed appropriately before increasing asthma therapy:

- smoking behaviour (because smoking interferes with asthma control)
- poor inhaler technique
- inadequate adherence to regular preventative asthma therapy
- rhinitis.

There is increasing evidence to support personalised asthma action plans in adults with persistent asthma. Contractors may wish to follow the advice of guidelines and offer a personalised asthma action plan to patients.

Peak flow is a valuable guide to the status of a patient's asthma, especially during exacerbations. However, it is much more useful if there is a record of their best peak flow (that is, peak flow when they are well). Many guidelines for exacerbations are based on the ratio of current to best peak flows. For patients aged 19 or over no particular time limit is needed for measuring best peak flow. However in view of the reduction in peak flow with age, it is recommended that the measurement be updated every few years. For patients aged 18 or under the peak flow will be changing; therefore it is recommended that the best peak flow be re-assessed annually. Inhaler technique is to be reviewed regularly. Clinical

[39] RCP. Pearson MG, Bucknall CE, editors. Measuring clinical outcomes in asthma: patient focused approach.
[40] Thomas M, Gruffydd-Jones K, Stonham C et al. Assessing asthma control in routine clinical practice: use of the RCP '3 Questions' 2009. PCRJ 18: 83-8

guideline emphasises the importance of assessing ability to use inhalers before prescribing and regularly reviewing technique, especially if control is inadequate. Inhalers are to be prescribed only after patients have received training in the use of the device and have demonstrated satisfactory technique. Reassess inhaler technique as part of their structured asthma review.

During an asthma review the following takes place:

- assess symptoms (using the three RCP questions)
- measure peak flow
- assess inhaler technique
- consider a personalised asthma plan.

If the asthma appears to be uncontrolled, follow the additional steps outlined above.

AST 003.2 Reporting and verification
See indicator wording for requirement criteria.

The Business Rules require that contractors code the review and the responses to the three RCP questions separately and on the same day in order to meet the requirements of this indicator.

AST indicator 004

The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months.

AST 004.1 Rationale
Many young people start to smoke at an early age. It is therefore justifiable to ask about smoking on an annual basis in this age group.

Studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. There are very few studies that have considered the question of whether smoking affects asthma severity. One controlled cohort study suggested that exposure to passive smoke at home delayed the recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control[41].

It is recommended that smoking cessation be encouraged as it is good for general health and may decrease asthma severity[42].

[41] Price et al. Clin Exp Allergy 2005; 35: 282-287
[42] Thomson et al. Euro Respiratory Journal 2004; 24: 822-833

AST 004.2 Reporting and verification
See indicator wording for requirement criteria.

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Initial diagnosis		
COPD002NI. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 15 months after entering on to the register	5	45–80%
Ongoing management		
COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months	9	70–90%
COPD004NI. The percentage of patients with COPD with a record of FEV_1 in the preceding 3 years	7	40–75%
COPD005NI. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 15 months	5	40-90%
COPD007. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	6	65-90%

COPD – rationale for inclusion of indicator set

COPD is a common disabling condition with a high mortality. The most effective treatment is smoking cessation. Oxygen therapy has been shown to prolong life in the later stages of the disease and has also been shown to have a beneficial impact on exercise capacity and mental state. Some patients respond to inhaled steroids. Many patients respond symptomatically to inhaled beta-agonists and anti-cholinergics. Pulmonary rehabilitation has been shown to produce an improvement in quality of life.

The majority of patients with COPD are managed by GPs and members of the primary care team with onward referral to secondary care when required. This indicator set focuses on the diagnosis and management of patients with symptomatic COPD.

COPD indicator 002NI

The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 15 months after entering on to the register.

COPD 002.1 Rationale
A diagnosis of COPD relies on clinical judgement based on a combination of history, physical examination and confirmation of the presence of airflow obstruction using spirometry.

Clinical guideline on COPD provides the following definition of COPD:

- airflow obstruction is defined as a reduced FEV_1/FVC ratio (where FEV_1 is forced expired volume in one second and FVC is forced vital capacity), such that FEV_1/FVC is < 0.7
- if FEV_1 is greater than or equal to 80 per cent predicted normal a diagnosis of COPD would only be made in the presence of respiratory symptoms, for example breathlessness or cough.

Clinical guideline requires post bronchodilator spirometry for diagnosis and gradation of severity of airways obstruction. Failure to use post bronchodilator readings has been shown to overestimate the prevalence of COPD by 25 per cent[43]. Spirometry is to be performed after the administration of an adequate dose of an inhaled bronchodilator (e.g. 400 mcg salbutamol).

Prior to performing post bronchodilator spirometry, patients do not need to stop any therapy, such as long-acting bronchodilators or inhaled steroids.

Routine reversibility testing is not recommended. However, where doubt exists as to whether the diagnosis is asthma or COPD, reversibility testing may add additional information to post bronchodilator readings alone and peak flow charts are useful. It is acknowledged that COPD and asthma can co-exist and that many patients with asthma who smoke will eventually develop irreversible airways obstruction. Where asthma is present, these patients would be managed as asthma patients as well as COPD patients. This will be evidenced by a greater than 400mls response to a reversibility test and a post bronchodilator FEV_1 of less than 80 per cent of predicted normal as well as an appropriate medical history.

Patients with reversible airways obstruction will be included on the asthma register. Patients with coexisting asthma and COPD will be included on the register for both conditions.

The guideline on COPD recommends that all health professionals involved in the care of patients with COPD have access to spirometry and be competent in the interpretation of the results.

[43] Johannessen et al. Thorax 2005; 60(10): 842-847

From April 2011 the diagnostic codes for this indicator were updated to include new codes for post bronchodilator spirometry. The previous codes for reversibility testing will not be acceptable for QOF purposes.

COPD 002.2 Reporting and verification
See indicator wording for requirement criteria.

COPD indicator 003

The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months.

COPD 003.1 Rationale
COPD is increasingly recognised as a treatable disease with large improvements in symptoms, health status, exacerbation rates and even mortality if managed appropriately. Appropriate management is based on clinical guidelines and international GOLD guidelines in terms of both drug and non-drug therapy.

In making assessments of the patient's condition as part of an annual review and when considering management changes it is essential that health care professionals are aware of:

1. current lung function
2. exacerbation history
3. degree of breathlessness (Medical Research Council (MRC) dyspnoea scale).

A tool such as the Clinical COPD Questionnaire[44] could be used to assess current health status.

Additionally there is evidence that inhaled therapies can improve the quality of life in some patients with COPD. However, there is evidence that patients require training in inhaler technique and that such training requires reinforcement. Where a patient is prescribed an inhaled therapy their technique is to be assessed during any review.

The MRC dyspnoea scale gives a measure of breathlessness and is recommended as part of the regular review.

COPD 003.2 Reporting and verification
See indicator wording for requirement criteria.

COPD indicator 004NI

The percentage of patients with COPD with a recorded FEV_1 in the preceding 3 years.

[44] Clinical COPD Questionnaire. http://www.ccq.nl/

COPD 004.1 Rationale
There is a gradual deterioration in lung function in patients with COPD. This deterioration accelerates with the passage of time. There are important interventions which can improve quality of life in patients with severe COPD. It is therefore important to monitor respiratory function in order to identify patients who might benefit from pulmonary rehabilitation or continuous oxygen therapy.

Clinical Guidelines on COPD recommends that FEV_1 and inhaler technique are assessed at least annually for patients with mild/moderate/severe COPD (and at least twice a year for patients with very severe COPD). The purpose of regular monitoring is to identify patients with increasing severity of disease who may benefit from referral for more intensive treatments/diagnostic review.

Contractors should identify those patients who could benefit from long-term oxygen therapy and pulmonary rehabilitation.

These measures require specialist referral because of the need to measure arterial oxygen saturation to assess suitability for oxygen therapy and the advisability of specialist review of patients prior to starting pulmonary rehabilitation.

The long-term administration of oxygen (more than 15 hours per day) to patients with chronic respiratory failure has been shown to increase survival and improve exercise capacity. Referral for consideration for long-term oxygen therapy and/or pulmonary rehabilitation is to be made to those with appropriate training and expertise. This may include a respiratory physician, a general physician or a GP with a special interest (GPwSI) in respiratory disease.

COPD 004.2 Reporting and verification
See indicator wording for requirement criteria.

COPD indicator 005NI

The percentage of patients with COPD and Medical Research Council dyspnoea grade $\geq$3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 15 months

COPD 005.1 Rationale
As COPD progresses, patients often become hypoxaemic. Many patients tolerate mild hypoxaemia well, but once the resting partial pressure of oxygen in arterial blood (PaO2) falls below 8 KPa patients begin to develop signs of right-sided HF (cor pulmonale), principally peripheral oedema. The prognosis is poor and if untreated the five year survival is less than 50 per cent.

In stable COPD, patients use oxygen therapy for long periods during the day and night. Long-term oxygen therapy can improve survival in patients with COPD who have severe hypoxaemia, where PaO2 is less than 8 KPa. It can also reduce the incidence of

polycythaemia (that is, raised red cell count), reducing the progression of pulmonary hypertension and improving psychological wellbeing.

Guidelines recommend that patients with oxygen saturations of 92 per cent or lower when breathing air, be considered for oxygen therapy. Pulse oximetry (SpO_2) provides an estimate of arterial oxygen saturation (SaO_2) and is non-invasive.

Pulse oximetry allows practitioners to assess patients' level of oxygen saturation to determine if whether referral for clinical assessment and long-term oxygen therapy is appropriate. Pulse oximetry is a valuable screening tool for identifying patients who are appropriate for referral for long-term oxygen therapy. A normal pulse oximetry reading (SpO_2 greater than 92 per cent) can reliably identify patients who do not need referral. However, pulse oximetry cannot predict which patients with an abnormal reading (SpO_2 of 92 per cent or lower) have sufficiently severe hypoxaemia to require long-term oxygen therapy, therefore these patients require further assessment.

COPD 005.2 Reporting and verification
See indicator wording for requirement criteria.

The Business Rules require that a record that pulse oximetry has been performed AND the resulting oxygen saturation value are recorded to meet the requirements for this indicator.

COPD indicator 007

The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March.

COPD 007.1 Rationale
This is a current recommendation from the CMO and the JCVI.

COPD 007.2 Reporting and verification
See indicator wording for requirement criteria.

Dementia (DEM)

Indicator	Points	Achievement thresholds
Ongoing management		
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months	15	55–70%
DEM003. The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before and 6 months after entering on to the register	6	45–80%

DEM – rationale for inclusion of indicator set

Dementia is a syndrome characterised by an insidious but ultimately catastrophic progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20 per cent at the age of 80. The annual incidence of vascular dementia is 1.2/100 overall person years at risk and is the same in all age groups. Alzheimers disease accounts for 50–75 per cent of cases of dementia.

The annual incidence of dementia of the Alzheimers type rises to 34.3/100 person years at risk in the 90 year age group; the prevalence is higher in women than in men due to the longer lifespan of women. Other types of dementia such as Lewy Body dementia and fronto-temporal dementia are relatively rare but can be very distressing. In a third of cases, dementia is associated with other psychiatric symptoms (depressive disorder, adjustment disorder, generalised anxiety disorder, alcohol related problems). A complaint of subjective memory impairment is an indicator of dementia especially where there is altered functioning in terms of activities of daily living.

DEM indicator 002

The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months.

DEM 002.1 Rationale
The face-to-face review focuses on support needs of the patient and their carer. In particular the review addresses four key issues:

1. an appropriate physical and mental health review for the patient

2. if applicable, the carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs

3. if applicable, the impact of caring on the care-giver

4. communication and co-ordination arrangements with secondary care (if applicable).

A series of well-designed cohort and case control studies have demonstrated that patients with Alzheimer-type dementia do not complain of common physical symptoms, but experience them to the same degree as the general population. Patient assessments therefore include the assessment of any behavioural changes caused by:

- concurrent physical conditions (e.g. joint pain or inter-current infections)

- new appearance of features intrinsic to the disorder (e.g. wandering) and delusions or hallucinations due to the dementia or as a result of caring behaviour (e.g. being dressed by a carer).

Depression could also be considered as it is more common in patients with dementia than those without[45].

Patients and carers are to be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia[46]. As the illness progresses, needs may change and the review may focus more on issues such as respite care.

There is good evidence from well designed cohort studies and case control studies of the benefit of healthcare professionals asking about the impact of caring for a person with dementia and the effect this has on the caregiver. It is important to remember that male carers are less likely to complain spontaneously and that the impact of caring is dependent not on the severity of the cognitive impairment but on the presentation of the dementia, for example, on factors such as behaviour and affect. If the carer is not registered at the practice, but the GP is concerned about issues raised in the consultation, then with appropriate permissions they can contact the carer's own GP for further support and treatment.

As the illness progresses and more agencies are involved, the review could additionally focus on assessing the communication between health and social care and non-statutory sectors as appropriate, to ensure that potentially complex needs are addressed. Communication and referral issues highlighted in the review need to be followed up as part of the review process.

[45] Burt et al. Psychol Bull 1995; 117: 285-305
[46] Eccles et al. BMJ 1998; 317: 802-808

Further information

The Audit Commission Report. Forget me not 2002. http://www.audit-commission.gov.uk/nationalstudies/health/mentalhealth/Pages/forgetmenot2002.aspx

The NSF for Older People.
http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066

Coping with Dementia – a Handbook for Carers 2008.
http://www.healthscotland.com/uploads/documents/7632-CopingWithDementia2008.pdf

DEM 002.2 Reporting and verification
See indicator wording for requirement criteria.

Verification – the Regional Board may require randomly selecting a number of patient records of patients in which the review has been recorded as taking place to confirm that the four key issues are recorded as having been addressed, if applicable.

DEM indicator 003

The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before and 6 months after entering on to the register.

DEM 003.1 Rationale
There is no universal consensus on the appropriate diagnostic tests to be undertaken in those with suspected dementia. However, a review of 14 guidelines and consensus statements found considerable similarity in recommendations[47]. The main reason for undertaking investigations in a patient with suspected dementia is to exclude a potentially reversible or modifying cause for the dementia and to help exclude other diagnoses (e.g. delirium). Reversible or modifying causes include metabolic and endocrine abnormalities (e.g. vitamin B12 and folate deficiency, hypothyroidism, diabetes and disorders of calcium metabolism).

Clinical Guidelines on dementia state that a basic dementia screen is performed at the time of presentation, usually within primary care. It includes:

- routine haematology
- biochemistry tests (including electrolytes, calcium, glucose, and renal and liver function)

[47] Beck C, Cody M, Souder E et al. Dementia diagnostic guidelines: methodologies, results and implementation costs 2000. Journal of the Am Geriatrics Society 48: 1195-1203

- thyroid function tests
- serum vitamin B12 and folate levels.

DEM 003.2 Reporting and verification
See indicator wording for requirement criteria.

For the purpose of this indicator, if a test for HbA1c has been carried out within the timeframe permitted by this indicator, then a test for glucose would not be required. All tests are required to be carried out (with the exception of glucose in the above scenario) to meet the requirements of this indicator. Where the test is declined by the patient, then the patient may be exception reported.

This indicator only applies to patients with a new diagnosis of dementia in the QOF year. However the workload has the potential to span more than one QOF year. Therefore the associated Business Rules cover 18 months to capture patients whose care could span more than one QOF year e.g. six months before or after a new diagnosis is recorded.

Depression (DEP)

Indicator	Points	Achievement thresholds
Initial diagnosis		
DEP001NI. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had an assessment of the physical, psychological and social aspects of the condition by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded	21	50–90%

DEP – rationale for inclusion of the indicator set

Depression is common and disabling.

In 2000, the estimated point prevalence for a depressive episode among people aged 16 or over and under the age of 74 in the UK was 2.6 per cent (males 2.3 per cent, females 2.8 per cent). If the broader and less specific category of 'mixed depression and anxiety' is included, these figures increase dramatically to 11.4 per cent (males 9.1 per cent, females 13.6 per cent). It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after CVD in terms of the world's disabling diseases[48]. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In 2000, 109.7 million lost working days and 2615 deaths were attributable to depression. The total annual cost of adult depression in England has been estimated at over £9 billion, of which £370 million represents direct treatment costs.

DEP indicator 001NI

The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had an assessment of the physical, psychological and social aspects of the condition by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded.

DEP 001.1 Rationale
Clinical Guidelines for depression in adults states that patients with suspected depression have a comprehensive assessment which includes severity of symptoms, degree of functional impairment and/or disability associated with the possible depression and duration of the episode.

[48] Murray CJL and Lopez AD. The global burden of disease. Boston, Mass: WHO and Harvard University Press, 1996.

Consideration may also be given to factors which may have affected the development, course and severity of this episode such as past history of depression, previous treatments and access to personal and social support. The guideline also recommends that people with depression are asked directly about suicidal ideation and intent.

An assessment of the physical, psychological and social aspects of the condition (Biopsychosocial assessment - BPA) by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded.

The assessment follows good clinical practice and addresses the following:

- current symptoms including duration and severity
- personal history of depression
- family history of mental illness
- the quality of interpersonal relationships with, for example, partner, children and/or parents
- living conditions
- social support
- employment and/or financial worries
- current or previous alcohol and substance use
- suicidal ideation
- discussion of treatment options
- any past experience of, and response to, treatments.

Additionally, clinicians may wish to address the following:

- co-morbid mental health or physical disorders
- any past history of mood elevation, to determine if the depression may be part of a bipolar disorder
- awareness of sources of help
- patient's views of the cause of their symptoms
- discussion of the need for follow-up.

In circumstances where a patient is diagnosed with depression outside of primary care, contractors may exception report or use the indicator thresholds.

DEP 001.2 Reporting and verification
See indicator wording for requirement criteria.

The disease register for the depression indicators for the purpose of calculating the APDF is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

The indicator requires that the diagnosis of depression and the BPA codes are recorded on the same date to meet the requirements for this indicator.

This indicator requires that the contractor records the BPA as complete at the same time that diagnosis is recorded. When the BPA and diagnosis of depression are made in secondary care by specialist mental health services and the contractor doesn't know whether the BPA has been completed, the contractor can exception report the patient. This is because once a patient has been diagnosed with depression, it is not clinically appropriate to deliver a further BPA.

Suspected depression seen in secondary care may not always be referred to specialist mental health services for further assessment and management. It may be in the form of a discharge letter from an acute medical or surgical ward, A&E or from an outpatient appointment. It may be reasonable in these circumstances for a contractor to contact the patient to ask them to attend for an assessment to assess if they have a clinical diagnosis of depression. In such cases, the BPA can be carried out at that time.

Verification - the Regional Board may wish to review the records of patients who are claimed as a success against this indicator to ensure that all essential elements of the assessment have been recorded.

Mental health (MH)

Indicator	Points	Achievement thresholds
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate	6	30-55%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months	4	50–90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months	4	50–90%
MH008NI. The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years	5	45–80%
MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months	1	50–90%
MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months	2	50–90%

MH – rationale for inclusion of indicator set

This indicator set reflects the complexity of mental health problems, and the complex mix of physical, psychological and social issues that present to GPs.

Indicators MH002 – MH008 relate to the care of patients with a diagnosis of schizophrenia, bipolar or other affective disorders. Indicators MH009 and MH010 relate to the care of patients who are currently prescribed lithium.

For many patients with mental health problems, the most important indicators relate to the interpersonal skills of the doctor, the time given in consultations and the opportunity to discuss a range of management options.

This indicator set focuses on patients with serious mental illness. There are separate indicator sets that focus on patients with depression and dementia.

Mental health indicators MH003 – MH008NI
It is recommended that patients receive an annual health promotion and prevention review and advice appropriate to their age, gender and health status.

The components of an annual review have been separated out to create a series of indicators.
Clinical guideline on bipolar disorder recommends that patients with bipolar affective disorder have an annual physical health review, normally in primary care, to ensure that the following are assessed each year:

- lipid levels, including cholesterol in all patients aged 40 or over even if there is no other indication of risk
- plasma glucose levels
- weight
- smoking status and alcohol use
- blood pressure.

In addition to lifestyle factors, such as smoking, poor diet and lack of exercise, antipsychotic drugs vary in their liability for metabolic side effects such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance or dyslipidaemia) which is a predictor of type 2 diabetes and CHD[49].

MH indicator 002

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the records, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate.

MH 002.1 Rationale

Patients on the mental health disease register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a plan for care. This consultation may include the views of their relatives or carers where appropriate.

[49] Mackin P, Bishop D, Watkinson H et al. Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community 2007. BJP 191: 23-9.

Up to half of patients who have a serious mental illness are seen only in a primary care setting. For these patients, it is important that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record.

When constructing the primary care record, research supports the inclusion of the following information:

1. Patient's current health status and social care needs including how needs are to be met, by whom, and the patient's expectations.

2. How socially supported the individual is: e.g. friendships/family contacts/voluntary sector organisation involvement. People with mental health problems have fewer social networks than average, with many of their contacts related to health services rather than sports, family, faith, employment, education or arts and culture. One survey found that 40 per cent of people with ongoing mental health problems had no social contacts outside mental health services[50].

3. Co-ordination arrangements with secondary care and/or mental health services and a summary of what services are actually being received.

4. Occupational status. In England, only 24 per cent of people with mental health problems are currently in work, the lowest employment rate of any group of people (Office of National Statistics (ONS) Labour Force Survey, autumn 2003). People with mental health problems also earn only two thirds of the national average hourly rate (ONS, 2002). Studies show a clear interest in work and employment activities among users of mental health services with up to 90 per cent wishing to go into or back to work[51].

5. "Early warning signs" from the patient's perspective that may indicate a possible relapse[52]. Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the patient thinks may have acted as triggers.

6. The patient's preferred course of action (discussed when well) in the event of a clinical relapse, including who to contact and wishes around medication.

It is recommended that a care plan is accurate, easily understood, reviewed annually and discussed with the patient, their family and/or carers. If a patient is treated under the care programme approach (CPA), then they have a documented care plan discussed with their community key worker available. This is acceptable for the purposes of QOF.

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[50] See Ford et al. Psychiatric Bulletin 1993. 17(7): 409-411 and office of the Deputy Prime Minister, Mental health and social exclusion (Social Exclusion Unit Report) 2004. ODPM.

[51] See Grove and Drurie. Social firms: an instrument for social and economic inclusion. Redhill, Social Firms UK, 1999.

[52] Birchwood et al. Advances in Psychiatric Treatment 2000; 6: 93-101 and Birchwood and Spencer. Clinical Psychology Review 2001; 21(8): 1211-26

Where a patient has relapsed after being recorded as being in remission their care plan should be updated subsequent to the relapse. Care plans dated prior to the date of the relapse will not be acceptable for QOF purposes.

MH 002.2 Reporting and verification
See indicator wording for requirement criteria.

Verification - the Regional Board may require contractors to randomly select a number of care plans to ensure that they are being maintained annually.

MH indicator 003

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months.

MH 003.1 Rationale
Patients with schizophrenia have mortality between two and three times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population. A recent prospective record linkage study of the mortality of a community cohort of 370 patients with schizophrenia found that the increased mortality risk is probably life-long and it suggested that cardiovascular mortality of schizophrenia has increased over the past 25 years relative to the general population[53]. Clinical Guidelines on bipolar disorder also states that the standardised mortality ratio for cardiovascular death may be twice that of the general population but appears to be reduced if patients adhere to long-term medication.

Hypertension in people with schizophrenia is estimated at 19 per cent compared with 15 per cent in the general population[54]. A cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans' administration facilities found a prevalence of hypertension of 35 per cent[55].

There is evidence to suggest that physical conditions such as cardiovascular disorders go unrecognised in psychiatric patients. A direct comparison of cardiovascular screening (blood pressure, lipid levels and smoking status) of patients with asthma, patients with schizophrenia and other attendees indicated that general practice were less likely to screen patients with schizophrenia for cardiovascular risk compared with the other two groups[56].

Recording (and treating) cardiovascular risk factors are therefore very important for patients with a serious mental illness.

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[53] Brown S, Kim M, Mitchell C et al. 25 year mortality of a community cohort with schizophrenia. BJP 196: 116-21 2010.
[54] Hennekens C, Hennekens A, Hollar D. Schizophrenia and increased risks of CVD 2005. Am Heart Journal 150: 1115-21
[55] Kilbourne AM, Cornelius JR, Han X et al. Burden of general medical conditions among individuals with bipolar disorder 2004. Bipolar Disorder 6: 368-73
[56] Roberts L, Roalfe A, Wilson S et al. Physical health care of patients with schizophrenia in primary care: a comparative study 2007. FamPract 24: 34-40

MH 003.2 Reporting and verification
See indicator wording for requirement criteria.

MH indicator 007

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months.

MH 007.1 Rationale
Substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects[57]. The National Psychiatric Morbidity Survey in England found that 16 per cent of people with schizophrenia were drinking over the recommended limits of 21 units of alcohol for men and 14 units of alcohol for women a week[58, 59]. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse[60].

MH 007.2 Reporting and verification
See indicator wording for requirement criteria.

MH indicator 008NI

The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years

MH 008.1 Rationale
A report by the Disability Rights Commission based on the primary care records of 1.7 million primary care patients found that women with schizophrenia were less likely to have had a cervical sample taken in the preceding five years (63 per cent) compared with the general population (73 per cent). This did not apply to patients with bipolar affective disorder[61]. This finding may reflect an underlying attitude that such screening is less appropriate for women with schizophrenia. This indicator therefore encourages contractors to ensure that women with schizophrenia, bipolar affective disorder or other psychoses are given cervical screening according to national guidelines.

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[57] RCP Research and Training Unit. Banerjee S, Clancy C, Crome I, editors. Co-existing problems of mental disorder and substance misuse (dual diagnosis) 2001. Information manual.
[58] Meltzer H, Gill B, Pettigrew M et al. OCPS Survey of Psychiatric Morbidity in GB. Report 3: Economic activity and social functioning of adults with psychiatric disorders 1996.
[59] Farrell M, Howes S, Taylor C et al. Substance misuse and psychiatric co-morbidity: an overview of the OCPS National Psychiatric Morbidity Survey. Addictive behaviours 23: 909-18 1998.
[60] Kessler RC, Rubinow DR, Holmes C et al. The epidemiology of DSM-III-R bipolar I disorder in a general population survey. Psychological Medicine 27: 1079-89 1997.
[61] Hippisley-Cox J, Pringle M. Health inequalities experienced by people with schizophrenia and manic depression: Analysis of general practice data in England and Wales. QRESEARCH 2005. www.qresearch.org/SitePages/publications.aspx

MH 008.2 Reporting and verification
See indicator wording for requirement criteria.

MH indicator 009

The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months

MH 009.1 Rationale
It is important to check thyroid and renal function regularly in patients taking lithium, as there is a much higher than normal incidence of hypothyroidism and hypercalcaemia and of abnormal renal function tests. Overt hypothyroidism has been found in between eight per cent and 15 per cent of patients on lithium.

Clinical Guidelines recommend that practitioners check thyroid function every six months together with levels of thyroid antibodies if clinically indicated (for example, by the thyroid function tests). It also recommends that renal function tests are carried out every six months and more often if there is evidence of impaired renal function.

MH 009.2 Reporting and verification
See indicator wording for requirement criteria.

Due to the way repeat prescribing works in general practice, patients on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

MH indicator 010

The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months.

MH 010.1 Rationale
Lithium monitoring is essential due to the narrow therapeutic range of serum lithium and the potential toxicity from inter-current illness, declining renal function or co-prescription of drugs, for example thiazide diuretics or non-steroidal anti-inflammatory drugs (NSAIDs) which may reduce lithium excretion.

The National Patient Safety Agency (NPSA) recently conducted a review of the use of oral lithium for bipolar disorder, which demonstrated that wrong or unclear dose or strength and monitoring were key issues for lithium therapy[62]. A search of all medication incidents related to the use of lithium reported to the National Reporting and Learning System between November 2003 and December 2008 identified a total of 567 incidents. Two of these resulted in 'severe' harm to the patient, although the majority were reported as 'no harm' events[63].

[62] NPSA alert 0921. Safer lithium therapy 2009. www.nrls.npsa.uk/alerts
[63] Prescribing Observatory for Mental Health. Topic 7 baseline report. Monitoring of patients prescribed lithium: baseline. 2009.

Clinical guidelines state that for patients with bipolar disorder on lithium treatment, prescribers:

- monitor serum levels normally every three months
- monitor older adults carefully for symptoms of lithium toxicity, because they may develop high serum levels of lithium at doses in the normal range and lithium toxicity is possible at moderate serum levels.

The aim is to maintain serum lithium levels between 0.6 and 0.8 mmol/l in patients who are prescribed lithium for the first time. For patients who have relapsed previously while taking lithium or who still have sub-threshold symptoms with functional impairment while receiving lithium, a trial of at least six months with serum lithium levels between 0.8 and 1.0 mmol/l should be considered. If the range differs locally, the Regional Board will be required to allow for this.

Where a contractor is prescribing lithium, they are responsible for checking that routine blood tests have been done (not necessarily by the practice) and for following up patients who default.

MH 010.2 Reporting and verification
See indicator wording for requirement criteria.

Due to the way repeat prescribing works in general practice, patient on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

Cancer (CAN)

Indicator	Points	Achievement thresholds
Ongoing management		
CAN003. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis	6	50–90%

CAN – rationale for inclusion of indicator set

It is recognised that the principal active management of cancers occurs in the secondary care setting. However, general practice often has a key role in the referral and subsequent support of these patients and in ensuring that care is appropriately co-ordinated. This indicator set is not evidence-based but does represent good professional practice.

CAN indicator 003

The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis.

CAN 003.1 Rationale

A GP will have an average of eight or nine new cancer diagnoses per year and will be looking after 20 to 30 patients with cancer. The increasing number of cancer survivors has led to an increase in the number of people requiring follow-up care, monitoring and management. Given the importance of primary care practitioners making early contact with patients who have been diagnosed with cancer, the timeframe for this indicator has been set at six months.

Most practices will see patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting. These patients quickly resume consultations in general practice at an increased rate to pre-diagnosis and treatment, therefore primary care has an important role in managing survivorship. This review represents an initial opportunity to address patients' needs for individual assessment, care planning and on-going support and information requirements.

A cancer review in primary care includes:

- The patient's individual health and support needs, which will vary with, for example, the diagnosis, staging, age and pre-morbid health of the patient and their social support networks. In collaboration with the National Cancer Survivorship Initiative

(NCSI)[64], Macmillan primary care community has produced a template[65] which recommends that this could cover a discussion of the diagnosis and recording of cancer therapy, an offer of relevant information, medication review, benefits counselling and recording of a carer's details.

- The coordination of care between sectors.

Further information on survivorship and the potential role for primary care can be found on the NCSI website[66].

It is preferable that a review should be face-to-face in most cases, making contact with a patient over the telephone will meet the requirements for this indicator. Where contact is made over the phone, an offer of a subsequent face-to-face review is advised.

CAN 003.2 Reporting and verification

See indicator wording for requirement criteria.

Verification – the Regional Board may wish to review records where a review is claimed to confirm that both elements have been completed.

[64] NCSI. http://www.ncsi.org.uk/what-we-are-doing/assessment-care-planning/cancer-care-review/
[65] Macmillan primary care community template. http://www.ncsi.org.uk/wp-content/uploads/EMIS-guide-info.pdf
[66] NCSI website. http://www.ncsi.org.uk/

Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	Points	Achievement thresholds
Ongoing management		
OST002. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent	3	30–60%
OST005. The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent	3	30–60%

OST – rationale for inclusion of indicator set

Osteoporotic fragility fractures can cause substantial pain and severe disability and are associated with decreased life expectancy. Osteoporotic fragility fractures occur most commonly in the spine (vertebrae), hip (proximal femur) and wrist (distal radius). They also occur in the arm (humerus), pelvis, ribs and other bones. Fractures of the hands and feet (for example metacarpal and metatarsal fractures) are not generally regarded as osteoporotic fragility fractures.

Interventions for secondary prevention of fractures in patients who have had an osteoporotic fragility fracture include pharmacological intervention.

OST indicator 002

The percentage of patients aged 50 or over and who have not attained the age of 75 with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent

OST 002.1 Rationale

The management of osteoporosis includes lifestyle advice, such as advice on adequate nutrition, regular weight-bearing exercise, stopping smoking and avoiding alcohol, to reduce the risks of osteoporosis. Interventions for secondary prevention of fractures in patients who have had an osteoporotic fragility fracture include pharmacological intervention.

Clinical guidelines on the management of osteoporosis address the pharmacological management in three groups of postmenopausal women: postmenopausal women with

multiple vertebral fractures (DXA scan not essential but other destructive diseases are excluded); postmenopausal women with osteoporosis determined by DXA scan and a history of at least one vertebral fracture; and postmenopausal women with osteoporosis determined by DXA scan with or without a previous non-vertebral fracture.

For all these groups bone-sparing agents are indicated to reduce subsequent fracture risk. Technology appraisal states that the bone-sparing agent alendronate is recommended as a treatment option for the secondary prevention of osteoporotic fragility fractures in postmenopausal women who are confirmed to have osteoporosis. When the decision has been made to initiate treatment with alendronate, it is recommended that the preparation prescribed is chosen on the basis of the lowest acquisition cost available. The bone-sparing agents risedronate and etidronate are recommended as alternative treatment options for secondary prevention of osteoporotic fragility fractures in postmenopausal women:

- who are unable to comply with the special instructions for the administration of alendronate, or have a contraindication to or are intolerant of alendronate and

- who also have a combination of T-score, age and number of independent clinical risk factors for fracture as indicated in the following table.

Table 5. T-scores (SD) at (or below) which risedronate or etidronate is recommended when alendronate cannot be taken

Age (years)	Number of independent clinical risk factors for fracture*		
	0	1	2
50-54	-**	-3.0	-2.5
55-59	-3.0	-3.0	-2.5
60-64	-3.0	-3.0	-2.5
65-69	-3.0	-2.5	-2.5
70 or over	-2.5	-2.5	-2.5

*Independent clinical risk factors for fractures are parental history of hip fracture, alcohol intake of four or more units per day, and rheumatoid arthritis.
**Treatment with risedronate or etidronate is not recommended.

In deciding between risedronate and etidronate, clinicians and patients need to balance the overall proven effectiveness profile of the drugs against their tolerability and adverse effects in individual patients.

Clinical guidelines makes recommendations on men with a diagnosis of osteoporosis determined by DXA scan. It states that to reduce fracture risks at all sites, men with low BMD and/or a history of one or more vertebral fractures or one non-vertebral osteoporotic fractures are treated with oral alendronate.

It is recommended that calcium and vitamin D supplementation are used in combination with bone-sparing agents. The guideline also recommends that patients who have had a fragility fracture who require treatment with a bone-sparing agent also receive appropriate calcium and/or vitamin D supplementation.

OST 002.2 Reporting and verification
See indicator wording for requirement criteria.

OST indicator 005

The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who are currently treated with an appropriate bone-sparing agent.

OST 005.1 Rationale
See OST 002.1.

This indicator does not require that a diagnosis of osteoporosis is confirmed by DXA scan in patients aged 75 or over with a fragility fracture. But it is recommended clinical practice that this group are considered for a DXA scan. Guidelines recommend that a diagnosis of osteoporosis may be assumed in women aged 75 or over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible[67]. Guidance recommends that in frail elderly women (aged 80 or over) a DXA scan would be a prerequisite to establish BMD is sufficiently low before starting treatment with bone-sparing agents (biophosphonates), unless the patient has suffered multiple vertebral fractures.

OST 005.2 Reporting and verification
See indicator wording for requirement criteria.

A diagnosis of osteoporosis is not required in patients aged 75 or over who have a fragility fracture. If, however, a patient aged 80 or over has a DXA scan and this shows the patient not to have osteoporosis then the patient can be exception reported.

[67] NICE technology appraisal TA161.

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months	5	40–90%
RA003NI. The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 3 years	7	40–90%
RA004. The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 3 years	5	40–90%

RA – rationale for inclusion of indicator set

Rheumatoid arthritis (RA) is a chronic, disabling auto-immune disease characterised by inflammation in the peripheral joints, which causes swelling, stiffness, pain and progressive joint destruction. For a small proportion of people with RA, inflammatory disease outside the joints (for example, eye and lung disease, vasculitis) can pose a significant problem. RA affects around one per cent of the population; of these people, approximately 15 per cent have severe RA.

Although the confirmation of diagnosis and initiation of treatment may take place in secondary care, primary care has an important role to play in the management of RA. This may include checking cardiovascular risk and blood pressure, checking the person's risk for osteoporosis and assessing for signs of low mood or depression. An annual face-to-face review in primary care is an opportunity to assess the effect of the disease upon the person's life, for example side effects to medication and whether they would benefit from any referrals to the multi-disciplinary team.

RA indicator 002

The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months.

RA 002.1 Rationale
RA is a chronic disease with a variable course over a long period of time. Therefore, there is a need for regular monitoring to determine disease status, assess severity, efficacy and toxicity of drug therapy and identify co-morbidities or complications.

Patients with satisfactorily controlled established disease require review appointments for ongoing drug monitoring, additional visits for disease flares and rapid access to specialist care. RA and its treatment can also have a negative effect upon a patient's quality of life. It is recommended that contractors review the following aspects of care with a patient:

- disease activity and damage, which may include requesting C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) or plasma viscosity test
- a discussion of DMARDS, if relevant
- the need for referral for surgery
- the effect the disease is having on their life, for example employment or education
- the need to organise appropriate cross-referral within the multi-disciplinary team.

As a minimum, it is advised that this review covers disease activity and damage, the effect of the disease upon the patient's life and whether they would benefit from any referrals to the multi-disciplinary team.

RA 002.2 Reporting and verification
See indicator wording for requirement criteria.

Verification - the Regional Board may wish to review patient records to ensure that all essential elements of the review have been performed.

RA indicator 003NI

The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 3 years.

RA 003.1 Rationale
RA is a significant, independent risk factor for CVD and causes increased mortality compared with the general population. The increased risk appears to be due to both an increased prevalence of traditional risk factors, such as smoking, in addition to inflammation.

Most existing CVD risk assessment models do not treat RA as an independent risk factor for CVD and therefore the scores underestimate the person's risk.

Currently, the only tool which adjusts for RA as an independent risk factor within the risk algorithm itself is QRISK2[68]. This tool was developed and validated using primary care data from 26,907 patients with RA.

This indicator may be updated with new tools which adjust for RA.

It is recommended that the CVD risk assessment is repeated annually, unless patients have established CVD (for example, CHD, stroke and transient ischemic attack), or familial hypercholesterolemia. The assessment is repeated annually because lipid levels have an impact on the risk of developing CVD and lipids may not be constant in patients with RA and therefore can change over a course of a year. RA treatment for the control of inflammations may alter lipid levels.

Further information

Goodson NJ, Wiles NJ, Lun M, et al. Mortality in early inflammatory polyarthritis: cardiovascular mortality is increased in seropositive patients 2002. Arthritis and Rheumatism; 46: 2010-19.

Aho K, Heliovaara M. Risk factors for RA 2004. Annals of Medicine; 36(4): 242-51.

Peters MJL, Symmons DPM, McCarey D, et al. EULAR evidence-based recommendations for cardiovascular risk management in patients with RA and other forms of inflammatory arthritis 2010. Annals of Rheumatic Diseases 69:325-331.

Hippisley-Cox J, Coupland C, Vinogrdova Y. et al. Predicting cardiovascular risk in England and Wales: prospective derivation and validation of QRISK2 2008. BMJ 336; 7659: 1475-1482.

Collins GS and Altman DG. An independent and external validation of QRISK2 CVD risk score: a prospective open cohort study 2010. BMJ 340; c2442.

RA 003.2 Reporting and verification
See indicator wording for requirement criteria.

Patients with CHD, stroke, transient ischemic attack, or familial hypercholesterolemia, are excluded from this indicator.

RA indicator 004

The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 3 years .

[68] QRISK2 website. http://qrisk.org/

RA 004.1 Rationale

Osteoporosis is more common in patients with RA because of reduced mobility, inflammation and the effects of pharmacological treatments, especially steroids. Clinical guidelines highlight the importance of checking for the development of osteoporosis. Therefore, assessing for risk of fracture is an important part of holistic primary care for patients with RA.

We propose that fracture risk assessment is considered in women aged 65 or over, in men aged 75 or over and in younger patients if they have the following risk factors:

- previous fragility fracture
- current use or frequent past use of oral glucocorticoids
- history of falls
- family history of hip fracture
- other secondary causes of osteoporosis including RA
- low BMI (less than 18.5 kg/m^2)
- smoking more than ten cigarettes per day
- alcohol intake of more than 14 units per week for women and more than 21 units per week for men.

However, it is recommended that fracture risk assessment is not routinely performed in patients aged 50 or under unless they have major risk factors such as current or frequent use of oral or systemic glucocorticoids, untreated, premature menopause or previous fragility fracture. Therefore, the age range for this indicator has been set at 50 or over and under the age of 91.

A ten year predicted absolute fracture risk can be calculated using either FRAX[69] (without a bone mineral density value) or QFracture[70].

FRAX is the WHO's fracture risk assessment tool which is available to use free of charge. It gives a ten year probability of hip fracture and a ten year probability of a major osteoporotic fracture (for example, clinical spine, forearm, shoulder or hip fracture).

QFracture is also available to use free of charge and it estimates an individual's risk of developing a hip fracture or an osteoporotic fracture (for example, hip, vertebral or distal radius fracture) over the next ten years. The original research was carried out using the QResearch anonymised primary care research database and has since been validated in a different primary care database.

[69] FRAX. http://www.shef.ac.uk/FRAX/
[70] Qfracture. http://www.qfracture.org/

Draft Guidance recommends that, following risk assessment, measurement of bone mineral density be considered:

- in patients whose fracture risk is in the region of the intervention threshold for proposed treatment; or
- before starting treatments that may adversely affect bone density, for example high dose glucocorticoids.

Absolute fracture risk is then recalculated using FRAX.

The draft guidance also recommends that fracture risk be recalculated when there is a change in the patient's risk factors or after a minimum of two years if the original calculated risk was close to the intervention threshold for treatment. This indicator requires that fracture risk assessment is recalculated every3 years.

Further information

Hippisley-Cox J and Coupland C. Derivation and validation of updated QFracture algorithm to predict risk of osteoporotic fracture in primary care in the UK prospective open cohort study 2012. BMJ. 344;e3427.

Collins GS and Altman DG. Predicting risk of osteoporotic and hip fracture in the UK: prospective independent and external validation of QFracture scores 2011. BMJ. 342;d3651.

RA 004.2 Reporting and verification
See indicator wording for requirement criteria.

Patients with a pre-existing diagnosis of osteoporosis or who are currently treated with bone-sparing agents will be excluded from this indicator.

Palliative care (PC)

Indicator	Points	Achievement thresholds
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	
Ongoing management		
PC002. The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed	3	

PC – rationale for inclusion of indicator set

Palliative care is the active total care of patients with life-limiting disease and their families by a multi-professional team. The first National End of Life Care (EoLC) Strategy[71] was published in July 2008. It builds on work such as the NHS cancer plan 2000 and NHS EOLC programme 2005.

The way primary care teams provide palliative care in the last months of life has changed and developed extensively in recent years with:

- since the introduction of this indicator set over 99 per cent of practices now using a palliative care register
- specific emphasis on the inclusion of patients with non-malignant disease and of all ages since April 2008
- patients and carers being offered more choice regarding their priorities and preferences for care including their preferred place of care in the last days of life (evidence shows that more patients achieve a home death if they have expressed a wish to do so)
- increasing use of anticipatory prescribing to enable rapid control of symptoms if needed and a protocol or integrated care pathway for the final days of life
- identification of areas needing improvement by the NAO e.g. unnecessary hospital admissions during the last months of life

The National EoLC Strategy suggests that all contractors adopt a systematic approach to EoLC and work to develop measures and markers of good care. They recommend the Gold Standards Framework (GSF) and the associated After Death Analysis (ADA) as examples of

[71] DH. National End of Life Care (EoLC) Strategy 2008. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

good practice. Evidence suggests that over 60 per cent of practices across the UK now use GSF to some degree to improve provision of palliative care by their primary care team.

The introduction of the GSF[72] to primary care and its associated audit tool, the ADA, are associated with a considerable degree of research and evaluation. The GSF provides ideas and tools that help contractors to focus on implementing high quality patient-centred care.

PC indicator 001

The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age.

PC 001.1 Rationale
About one per cent of the population in the UK die each year (over half a million), with an average of 20 deaths per GP per year. A quarter of all deaths are due to cancer, a third from organ failure, a third from frailty or dementia and only one twelfth of patients have a sudden death. It may therefore be possible to predict the majority of deaths, however, this is difficult and errors occur 30 per cent of the time. Two thirds of errors are based on over optimism and one third on pessimism. However, the considerable benefits of identifying these patients include providing the best health and social care to both patients and families and avoiding crises, by prioritising them and anticipating need.

Identifying patients in need of palliative care, **assessing** their needs and preferences and proactively **planning** their care, are the key steps in the provision of high quality care at the end of life in general practice. This indicator set is focused on the maintenance of a register (identifying the patients) and on regular multidisciplinary meetings where the team can ensure that all aspects of a patient's care have been assessed and future care can be co-ordinated and planned proactively[73].

A patient is included on the register if any of the following apply:

1. Their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask 'the 'surprise question' - 'Would I be surprised if this patient were still alive in 12 months?')

2. They have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have one core and one disease specific indicator in accordance with the GSF Prognostic Indicators Guidance (see QOF section of the GSF website)

3. They are entitled to a DS 1500 form (the DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered to be approaching the terminal stage of their illness. For these purposes, a patient is

[72] GSF. http://www.goldstandardsframework.org.uk/
[73] NAO EoLc Report. 'In one PCT 40 per cent of patients who died in hospital in October 2007 did not have medical needs which required them to be treated in hospital, and nearly quarter of these had been in hospital for over a month'. November 2008.

considered as terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months).

The register applies to all patients fulfilling the criteria regardless of age or diagnosis. The creation of a register will not in itself improve care but it enables the wider practice team to provide more appropriate and patient focussed care.

PC 001.2 Reporting and verification
See indicator wording for requirement criteria.

In the rare case of a nil register at year end, if a contractor can demonstrate that it established and maintained a register in the financial year then they will be eligible for payment.

PC indicator 002

The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed.

PC 002.1 Rationale
The aims of multi-disciplinary case review meetings are to:

- ensure all aspects of the patient's care have been considered and documented in the patient's records
- improve communication within the team and with other organisations (e.g. care home, hospital, community nurse specialist) and particularly improve handover of information to out-of-hours services
- co-ordinate each patient's management plan ensuring the most appropriate member of the team takes any action, avoiding duplication
- ensure patients are sensitively enabled to express their preferences and priorities for care, including preferred place of care
- ensure that the information and support needs of carers are discussed, anticipated and addressed wherever reasonably possible.

Many staff directly employed by the contractor find use of a checklist during the meeting helpful, as it helps to ensure all aspects of care are covered e.g. supportive care register (SCR) templates SCR1 and SCR2 the assessment tools on the GSF website.

PC 002.2 Reporting and verification
See indicator wording for requirement criteria.

Verification - the Regional Board may request that the contractor provides evidence that the meetings took place which could be in the form of minutes of the meetings. Contractors may also be required to provide written evidence describing the system for initiating and recording meetings.

Section 4: Public health (PH) domain

Public health domain introduction

The Public Health (PH) domain was introduced to QOF in April 2013. This was to recognise the commitment made in the November 2010 Government White Paper 'Healthy Lives, Healthy People: our strategy for Public Health England' for part of the QOF to be dedicated to evidence-based PH and primary prevention indicators.

The clinical and health improvement indicators within this domain follow the layout of the clinical domain indicators, referring to sections on the indicator rationale and reporting and verification.

Format

For each of the indicators (X.X) the following are described

X.1 Rationale
This section contains a range of information, dependent on the indicator, including:

- justification for the indicator
- a more detailed description of the indicator
- references which contractors may find useful.

X.2 Reporting and verification
This section outlines the evidence which the Regional Board may require the contractor to produce for verification purposes. The evidence would not need to be submitted unless requested. In some instances no evidence will be required but may be requested by the Regional Board at any time.

Cardiovascular disease – primary prevention (CVD-PP)

Indicator	Points	Achievement thresholds
Ongoing management		
CVD-PP011NI. The percentage of patients with a new diagnosis of hypertension recorded in the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who are aged 30 or over and who have not attained the age of 75, who have a CVD risk assessment score recorded in the preceding 15 months.	5	40–90%
CVD-PP012NI. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score in the preceding 15 months of ≥20%: the percentage who are currently treated with statins.	5	40– 90%

CVD-PP – rationale for inclusion of indicator set

Cardiovascular disease (CVD) is the most common cause of death in the UK and importantly for patients, the major cause of premature death (before the age of 65). This results in CVD being a major cost driver for health utilisation and remains the end point disease for many other chronic disorders, especially diabetes and renal disease.

CVD-PP indicator 011NI

The percentage of patients with a new diagnosis of hypertension recorded in the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who are aged 30 or over and who have not attained the age of 75, who have a CVD risk assessment score recorded in the preceding 15 months.

CVD-PP 011.1 Rationale
For primary prevention of CVD, people at risk need to be identified before CVD has become established. To assess risk in those likely to be at high-risk (for example, people with hypertension) a validated assessment tool is needed that evaluates a range of modifiable and non-modifiable risk factors.

A number of risk assessment tools can be used to estimate cardiovascular risk for this QOF indicator. These include:

- Framingham

- Joint British Society 2 (JBS2)
- QRISK.

The three assessment tools listed above allow a structured risk assessment to be undertaken. However, each has a different age threshold; so to include the use of all three tools, the age range for this indicator has been set at aged 30 or over and under the age of 75. Contractors will be expected to use one of the three tools to assess their patients. If the tool normally available on the contractor's clinical system is not age appropriate, one of the other tools may be used.

Framingham[74] and JBS2[75] are based on the American Framingham equations. These equations are of limited use in the UK because they were developed in a historic US population. The equations overestimate risk by up to 50 per cent in most contemporary northern European populations, particularly for people living in more affluent areas and underestimate risk in higher risk populations, such as people who are the most socially deprived. Framingham makes no allowance for a family history of premature CHD and does not take account of ethnicity, but does have a full data set.

The newer risk score QRISK has the advantage of including other variables, such as measures of social deprivation, ethnicity and family history. QRISK uses data from UK general practice databases.

Framingham and JBS2
The variables needed to estimate risk using the Framingham tool are age, sex, systolic blood pressure (mean of two previous systolic readings), total cholesterol, high density lipoprotein cholesterol, smoking status and presence of left ventricular hypertrophy. JBS2 uses the Framingham variables with the exception of the presence of left ventricular hypertrophy.

Framingham is an assessment of actual, not estimated, risk. The values used should have been recorded no longer than six months before the date of the risk assessment and before any treatment for hypertension. Framingham is not suitable for patients with pre-existing CVD (CHD, angina, stroke, TIA or PVD), diabetes, CKD (if the patient has an eGFR below 60) or familial hypercholesterolemia, or in patients already taking lipid-lowering medication before a new diagnosis of hypertension.

The Framingham risk score may be used in patients aged 35 or over and under the age of 75. JBS2 may be used in people aged 40 or over.

QRISK
The QRISK CVD risk calculator was developed by doctors and academics working in the NHS and is based on routinely collected data from GPs across the country. The current

[74] Anderson KM, Odell PM, Wilson PW et al. CVD risk profiles. Am Heart Journal 1991. 121: 293–8. Risk profile only. www.framinghamheartstudy.org/risk/coronary.html
[75] BCS/BHS/Diabetes UK et al. JBS guidelines on prevention of CVD in clinical practice 2005. Heart 91: 1–52

version of QRISK is QRISK2[76, 77]. QRISK2 uses the following variables to calculate CVD risk: self-assigned ethnicity, age, sex, smoking status, systolic blood pressure, total cholesterol, HDL cholesterol, BMI, family history of CHD in a first degree relative younger than 60, Townsend deprivation score, treated hypertension, type 2 diabetes, renal disease, AF and RA.

QRISK2 may be used in patients aged 30 or over and under the age of 85.

Clinical Guidelines on lipid modification makes recommendations on how a 10-year CVD risk score of 20 per cent or greater should be managed. It also makes recommendations on communication between practitioners and patients about CVD risk assessment and treatment. These include the following.

- Setting aside adequate time during the consultation to provide information on risk assessment and to allow any questions to be answered.
- Documenting the discussion relating to the consultation on risk assessment and the patient's decision.
- Offering information about the person's absolute risk of CVD and about the absolute benefits and harms of an intervention over a 10-year period. This information:
    1. presents individualised risk and benefit scenarios
    2. presents the absolute risk of events numerically
    3. uses appropriate diagrams and text.

See www.npci.org.uk for more information about explaining risk.

The guideline also recommends that if the patient's CVD risk is considered to be at a level that merits intervention but they decline the offer of treatment, they are advised that their CVD risk should be considered again in the future. The guideline also notes that CVD risk may be underestimated in people who are already taking anti-hypertensive or lipid modification therapy, or who have recently stopped smoking. It recommends that clinical judgement be used in such cases to decide on further treatment of risk factors in people who are below the 20 per cent CVD risk threshold.

For patients with hypertension, the guideline recommends that before they are offered lipid modification therapy for primary prevention, all other modifiable CVD risk factors are considered and their management optimised if possible. Baseline blood tests and clinical assessment are to be performed and co-morbidities and secondary causes of dyslipidaemia treated. Assessment includes:

- smoking status

[76] Hippisley-Cox J, Coupland C, Vinogradova Y et al. Predicting cardiovascular risk in England and Wales: prospective derivation and validation of QRISK2 2008. BMJ 336: 1475–82
[77] QRISK. www.qrisk.org

- alcohol consumption
- BMI or other measures of obesity
- fasting total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides (if fasting levels are not already available)
- fasting blood glucose
- renal function
- liver function (transaminases)
- TSH if dyslipidaemia is present.

Guidelines on lipid modification also recommend that the decision whether to initiate statin therapy is made after an informed discussion between the responsible clinician and the person about the risks and benefits of statin treatment, taking into account additional factors such as co-morbidities and life expectancy.

The guideline also states that a target for total or LDL cholesterol is not recommended for people who are treated with a statin for primary prevention of CVD and that once a person has been started on a statin for primary prevention, repeat lipid measurement is unnecessary. It is recommended that clinical judgement and patient preference should guide the review of drug therapy and whether to review the lipid profile.

CVD-PP 011.2 Reporting and verification
See indicator wording for requirement criteria.

Patients with the following pre-existing conditions are excluded from this indicator:

- CHD or angina
- stroke or TIA
- peripheral vascular disease
- diabetes

CVD-PP 011.2 Reporting and verification
See indicator wording for requirement criteria.

CVD-PP indicator 012NI

In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk

assessment score in the preceding 15 months of ≥20%: the percentage who are currently treated with statins.

CVD-PP 012.1 Rationale
Clinical Guidelines on lipid modification[78] recommends statin therapy for the primary prevention of CVD for adults who have an estimated 20 per cent or greater 10-year risk of developing CVD.

Clinical effectiveness of primary prevention
For people without clinical evidence of CVD, statin therapy is associated with a reduction of fatal and nonfatal MI and the composite outcome CHD death or nonfatal MI, fatal and nonfatal stroke and revascularisation. In trials predominantly comprising primary prevention but including a minority of people with established CVD, meta-analysis found that statin therapy was associated with a reduction in the risk of all-cause mortality, fatal and nonfatal MI and the composite outcomes of CHD death, nonfatal MI, fatal or nonfatal stroke and coronary revascularisation. For primary prevention lower intensity statins are safe and cost-effective. It is recommended that treatment for the primary prevention of CVD in patients with hypertension be initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative statin preparation may be chosen.

Guidelines on lipid modification also recommend that the decision whether to initiate statin therapy is made after an informed discussion between the responsible clinician and the person about the risks and benefits of statin treatment, taking into account additional factors such as co-morbidities and life expectancy.

The guideline also states that a target for total or LDL cholesterol is not recommended for people who are treated with a statin for primary prevention of CVD and that once a person has been started on a statin for primary prevention, repeat lipid measurement is unnecessary. It is recommended that clinical judgement and patient preference should guide the review of drug therapy and whether to review the lipid profile.

CVD-PP 012.2 Reporting and verification
See indicator wording for requirement criteria.

Verification - the Regional Board may request that the contractor randomly selects a number of case records of patients recorded as having had a risk assessment, to confirm that the key risk factors have been addressed and that biochemical and other clinical data used to inform the risk assessment are up-to-date. The Regional Board may also require contractors to demonstrate that age-appropriate risk assessment tools have been used.

[78] NICE clinical guideline CG67. Lipid modification. www.nice.org.uk/guidance/CG67

Blood pressure (BP)

Indicator	Points	Achievement thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure measurement in the preceding 5 years	15	50–90%

BP indicator 002

The percentage of patients aged 45 or over who have a record of blood pressure measurement in the preceding 5 years.

BP 002.1 Rationale
This indicator replaces two 2012/13 indicators from the organisational domain on the measurement of blood pressure (Records 11 and 17). The previous two indicators have been merged to reflect changes in the construction of the indicator. The merged indicator is measured as a fractional indicator in common with other clinical and PH indicators. This change allows for the measurement of continuous quality improvement.

Detecting elevated blood pressure and, where indicated, treating it, is known to be an effective health intervention. Raised blood pressure is common if it is measured on a single occasion but with repeated measurement blood pressure tends to drop. Guideline recommendations for the diagnosis and treatment of hypertension[79] are to be followed by practitioners when deciding on whether to treat raised blood pressure.

The age limit of aged 45 or over, has been chosen as the vast majority of patients develop hypertension after this age. It is also to align the indicator more closely with the vascular checks programme and the cost-effectiveness modelling undertaken to support that programme. The age range 45 or over, coupled with a five year reference period, is designed to ensure that a blood pressure measurement takes place by the time someone reaches the age of 45.

It is anticipated that contractors will opportunistically check blood pressures in all adult patients.

BP 002.2 Reporting and verification
See indicator wording for requirement criteria.

[79] NICE clinical guideline CG34. Hypertension: management of hypertension in adults in primary care 2006. http://guidance.nice.org.uk/CG34

Smoking (SMOK)

Indicator	Points	Achievement thresholds
Records		
SMOK001NI. The percentage of patients aged 15 or over whose notes record smoking status in the preceding 3 years	10	50–90%

Requirements for recording smoking status

Smokers
For patients who smoke, smoking status should be recorded in the preceding 3 years for SMOK001NI .

Non-smokers
It is recognised that life-long non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 3 years for SMOK001NI until the end of the financial year in which the patient reaches the age of 25.

Once a patient is over the age of 25 years (e.g. in the financial year in which they reach they age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:

- never smoked after their 25th birthday for SMOK001

Ex-smokers
There are two ways in which a patient can be recorded as an ex-smoker. Ex-smokers can be recorded as such in the preceding 3 years for SMOK001NI. Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.

SMOK indicator 001NI

The percentage of patients aged 15 or over whose notes record smoking status in the preceding 3 years.

SMOK 001.1 Rationale
There is evidence that when doctors and other healthcare professionals advise patients to stop smoking, this is effective. This indicator examines whether smoking status is recorded in the patient record.
See requirements for recording smoking status for further information.

SMOK 001.2 Reporting and verification
See indicator wording for requirement criteria.

There is no APDF calculation for SMOK001.

Public health domain – additional services

For contractors providing additional services the following indicators apply.

Please note exception reporting does not apply to those additional services indicators that do not have achievement thresholds.

Cervical screening (CS)

Indicator	Points	Achievement thresholds
CS002NI. The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years	11	45–80%

CS indicator 002NI

The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years

CS 002.1 Rationale
This indicator is designed to encourage and incentivise contractors to continue to achieve high levels of uptake in cervical screening.

The contractor may be required to provide evidence of the number of eligible women, aged 25 or over and under the age of 65, who have had a cervical screening test performed in the last five years/60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 45 and 80 per cent, in a similar way to the clinical indicators.

Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criterion A require that three separate invitations are offered to the patient before that patient can be recorded as 'did not attend'. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA; or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

The exception reporting criteria are not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all three invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman to be exception reported for this period, criterion G which requires that a discussion has taken place between the patient and the practitioner before 'informed dissent' can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

England. NHS Cancer Screening Programme.
http://www.cancerscreening.nhs.uk/cervical/index.html

CS 002.2 Reporting and verification
See indicator wording for requirement criteria.

The Regional Board may require that the contractor can provide a computer print-out showing the number of eligible women on the contractor list, the number exception reported and the number who have had a cervical screening test performed in the preceding five years. Contractors can exception report patients in the same way as the clinical indicators and the Regional Board may enquire how patients who are exception reported are identified and recorded.

Sexual health (CON)

Indicator	Points	Achievement thresholds
CON003NI. The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception in the preceding 3 years.	3	70–90%

CON – rationale for inclusion of indicator

The vast majority of contractors are providing the additional service for contraception and many are also providing enhanced services including long acting reversible contraception (LARC) methods. All contractors providing any level of contraception need to be able to advise women about all methods to ensure they can make an informed choice. It is advised that clinical staff in practices are aware of local services and local referral pathways.

This indicator set seeks to increase the awareness of women seeking contraceptive advice in general practices of LARC methods and thus to increase the percentage of women using these methods[80].

CON indicator 003NI

The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor, who have received information from the contractor about long acting reversible methods of contraception in the preceding 3 years. .

CON 003.1 Rationale

Women requiring EHC are given detailed information about and offered a choice of all methods, including LARC. It is often possible (and in many cases ideal practice) to commence an ongoing method of contraception at the same time as EHC is given.

Some women seeking EHC may be best served by being offered an emergency IUD. Emergency IUDs offer a slightly longer window period for action after unprotected intercourse than hormonal EC; they have a higher efficacy in prevention of pregnancy - and they provide excellent ongoing contraception if required.

Information from the contractor in written and verbal form. Leaflets can be obtained from a number of sources however the FPA, a UK-wide sexual health charity, has an excellent

[80] See also J Fam Plann Reprod Health Care; 34(4): 000-000 "Attitudes of women in Scotland to contraception: a qualitative study to explore acceptability of long-acting methods. 2008. Anna Glasier, Jane Scorer, Alison Bigrigg.

range of contraception leaflets including 'Your guide to Contraception', which, amongst other things, indicated LARC and non-LARC methods clearly through the use of shading.

CON 003.2 Reporting and verification
See indicator wording for requirement criteria.

Section 5: Records and Systems (RS) domain

Indicator	Points	Achievement thresholds
RS001. General Practitioners in the contracting practice should use Clinical Communications Gateway (CCG) for referrals to all available Consultant led specialities.[1]	10	n/a
RS002. The Practice reviews its own CCG Referral Data. Firstly to ensure that ALL GPs, including locums, are using CCG for referrals to all (available) Consultant led specialities. Secondly to look at referral patterns compared to previous years and neighbouring practices.[2]	20	n/a
RS003. The practice engages with between three and six neighbouring practices to discuss outpatient referrals. This should include identifying any issues with CCG use and looking at referral patterns and pathways.[3]	20	n/a
RS004. The Practice codes Emergency/Unplanned Admissions on receipt of the final paper or electronic discharge letter[4]. Information should include Date of Admission, Speciality and Diagnosis.	20	65%[5]
RS005. The Practice runs the Data Quality in Practice (DQiP) minimum dataset queries (to include queries to calculate the electronic frailty index[6]) in conjunction with the R&S tool, supported by the clinical informatics team on a six monthly basis. The extracts are shared with HSCB in pseudonymised form. The Practice will create and maintain a patient frailty register by coding patients identified by the electronic frailty index, presented in a dashboard in the R&S tool, using the appropriate Read code for mild, moderate or severe frailty.[7]	30	n/a

1 The aim is to use CCG for ALL referrals to ALL (available) specialities. The emphasis will remain on Consultant Led Specialities although GPs are encouraged to use CCG for other destinations as they are added.

[2] Reviewing referral patterns compared to previous years and neighbouring practices can be undertaken as a Quality Improvement and Clinical Governance exercise. Benchmarking information relating to January to June 2016 obtained from CCG and PAS databases will be made available to practices by 1st October 2016.

[3] Small Groups should consist of between three and six practices unless the HSCB agrees otherwise. This meeting should last 2-3 hours. Practices are expected to contribute significantly in discussions and no other parties should be present.

[4] Use the most relevant Read code under the 8H2 hierarchy **(see page 107)**

[5] The median rate of coding by GP Practices of unplanned admissions in July to December 2015 was 79% for uniquely coded admissions.

[6.] *Age and Ageing* 2016; **45:** 353–360

[7.] The Practice will be provided with a list of patients in each category of frailty, in the R&S tool, and the relevant Read code.

RS indicator 001

General Practitioners in the contracting practice should use Clinical Communications Gateway (CCG) for referrals to all available Consultant led specialities.

RS 001.1 Rationale

The HSCB is committed to ensuring that CCG is the standard method of referral. The benefits include a reduction in time between the date of referral and patient being seen in outpatients and better traceability of referrals which should eliminate the potential for a referral being lost in transit.

RS 001.2 Reporting and verification

The contractor is required to review current use of CCG for outpatient referrals to consultant led specialities aiming for as near 100% as possible. Practices in Northern Ireland already all use CCG for more than 50% of referrals to Consultant Led Specialities (average 80%). Rather than having a threshold for achievement compared to PAS data for 2016/17, outcomes in this indicator will be benchmarked against other practices, taking into account destinations available locally. Those who are significantly behind their peers in their use of CCG will be offered mentoring rather than being financially penalised this year.

RS indicator 002

The Practice reviews its own CCG Referral Data. Firstly to ensure that ALL GPs, including locums, are using CCG for referrals to all (available) Consultant led specialities. Secondly to look at referral patterns compared to previous years and neighbouring practices.

RS 002.1 Rationale

CCG is the preferred method of referral for all Consultant Led Specialities. It is important that ALL GPs in the practice are using CCG. The destination choices have specific advice pages for clinicians developed between GPs and Consultants. It was never intended that use of CCG would be delegated to non-clinical staff. GPs remain responsible for the referral and those who are currently delegating referrals are encouraged to review this and seek peer support.

Where all GPs in the practice are using CCG for all Consultant Led referrals the practice can use this time to review their referral patterns as part of their Governance / Quality Improvement work.

RS 002.2 Reporting and verification
The contractor is asked to prepare a summary of their internal meeting reflecting on their CCG use and referral patterns in advance of discussions at the external meetings.

RS indicator 003

The practice engages with between three and six neighbouring practices to discuss outpatient referrals. This should include identifying any issues with CCG use and looking at referral patterns and pathways.

RS 003.1 Rationale
The purpose of this meeting is twofold. Firstly to promote CCG use, identify any common issues and address these in a peer group setting. Once CCG use is established the next step is to use practice generated (CCG) information to review outpatient referral patterns in a peer group setting.

RS 003.2 Reporting and verification
The practice is required to participate in a peer review meeting with between three and six neighbouring practices. This meeting should last a minimum of two hours.
Practices will be required to evidence date of meeting and GPs present from each practice. The report should summarise any issues identified with CCG use as well as discussion of referral patterns. The report must be submitted to the HSCB no later than 31 March 2017 on the optional template provided or in a document which clearly covers all aspects of the template.

RS indicator 004

The Practice codes Emergency/Unplanned Admissions on receipt of the final paper or electronic discharge letter. Information should include Date of Admission, Speciality and Diagnosis.

8H21.	Admit Medical Emergency
8H22.	Admit Surgical Emergency
8H23.	Admit Psychiatric Emergency
8H24.	Admit Geriatric Emergency
8H25.	Admit Paediatric Emergency
8H26.	Admit Gynaecological Emergency
8H27.	Admit Obstetric Emergency
8H28.	Admit Orthopaedic Emergency
8H29.	Admit ENT Emergency
8H2A.	Admit Trauma Emergency
8H2..	Other Emergency Admissions

N.B. The table above shows common codes for Emergency/Unplanned Admissions but the Practice should always seek to use the most relevant Read code from the 8H2 hierarchy.

RS 004.1 Rationale
Emergency/Unplanned Admissions are harmful, costly and result in poor patient satisfaction. The HSCB is seeking to work with Practices to identify patients at risk of emergency admission so that Practices have an opportunity to optimise the care of their patients at highest risk. This requires a robust on-going record of Emergency/Unplanned Admissions. If this key clinical event is recorded accurately in the GP record then it reduces the need to link the GP record to other data sets to develop risk prediction algorithms removing some of the information governance challenges. There was significant improvement in the rates of Read coding of Emergency/Unplanned Admissions during 2015 as Practices put in place processes to ensure robust coding procedures. Maximal benefit will be achieved when ALL Emergency/Unplanned Admissions across ALL Practices are recorded using an appropriate Read code and therefore the achievement threshold is raised to 65% to encourage practices to further improve coding rates.

RS 004.2 Reporting and verification
The R&S tool, provided by HSCB will generate tailored MIQUEST queries that the practice will run to produce a list of all recorded Emergency/Unplanned Admissions. The clinical informatics team will again be available to help Practices remotely run the MIQUEST queries. A dashboard within the R&S tool will provide the achievement percentage: calculated as count of uniquely recorded Emergency/Unplanned Admissions in the GP clinical system divided by the count of Emergency/Unplanned Admissions in the regional data warehouse.

A data sharing agreement will be provided to cover processing of pseudonymised data by HSCB on behalf of the practice and to outline the uses for aggregated versions of the data collected.

RS indicator 005
The Practice runs the Data Quality in Practice (DQiP) minimum dataset queries (to include queries to calculate the electronic frailty index) in conjunction with the R&S tool, supported by the clinical informatics team on a six monthly basis. The extracts are shared with HSCB in pseudonymised form.

The Practice will create and maintain a patient frailty register by coding patients identified by the electronic frailty index (eFI), presented in a dashboard in the R&S tool, using the appropriate Read code for mild, moderate or severe frailty.

RS 005.1 Rationale
With an ageing population and ever greater numbers of patients living with long term conditions 'Frail Elderly' continues to be one of the clinical priority areas identified by the Department of Health. The electronic frailty index is a validated risk scoring tool that uses routine primary care data to identify frail patients and categorise them into mild, moderate or severe frailty. The eFI has predictive validity for outcomes of mortality, hospitalisation and nursing home admission. Use of eFI therefore facilitates delivery of evidence-based interventions to improve outcomes for this vulnerable group of patients.

In keeping with the data sharing agreement with Practices secondary use of the de-identified aggregated data shared by GP Practices is increasingly being used by HSCB to develop population profile reports to inform needs based commissioning.

RS 005.2 Reporting and verification
Additional MIQUEST queries will be added to the DQiP minimum dataset queries to calculate eFI scores. Dashboards in the R&S tool will provide a list of patients in each category of frailty and the Read code the Practice should use to flag the patient's record. The second data extraction will verify that Practices have created frailty registers by using the appropriate Read code provided at the time of the first data extraction.

Section 6: Patient experience domain (PE)

Please note exception reporting does not apply to this domain.

Indicator	Points
PE001 NI The contractor undertakes a survey of patients who have had contact with the practice (face to face or telephone consultation or prescription) within the past year with the question "Would you recommend your GP practice to someone who has just moved into the local area?" **and one follow-up question (see below)** The contractor should survey at least 2% of the practice list size and need to get a minimum of 50 responses. A summary report is required to be submitted to the Regional Board by 31 March 2017	18

PE indicator 001 NI

The contractor undertakes a survey of patients who have had contact with the practice (face to face or telephone consultation or prescription) within the past year with the question

"Would you recommend your GP practice to someone who has just moved into the local area?"

1=extremely likely, 2=likely, 3=neither likely nor unlikely, 4=unlikely, 5=extremely unlikely, 6=don't know

In addition the contractor should include one follow-up question-

"Please can you tell us the main reason for the score you have given?" **OR**

"Please add any comments you would like to make about the practice?"

The contractor should survey at least 2% of the practice list size and need to get a minimum of 50 responses.

PE 001.1 Rationale

In order to get a better measure of the quality of patient experience it has been agreed that a simple "Recommendation Question" will provide the practice, their patients and the Regional Board with a simple, easily understandable measure which is comparable from year to year and between practices. When combined with a follow-up question it provides a mechanism to identify where services do not live up to patients' expectations.

PE 001.2 Reporting and verification

A summary report is required to be submitted to the Regional Board by 31 March 2017.

How to Survey Patients

There is no preferred survey methodology or constraints on using technology to collect the

data; a number of different methods would be suitable. The contractor should consider how all groups of patients can be encouraged to respond. Face to face interviews should not be used due to response bias. Patients should be reassured of anonymity.

Options include:

- Postcard Solution - Patients are given (sent) information and a questionnaire to complete and return on site (complete at home and post back).
- On-line feedback: patients are given information including a web link which they can use to log on, enter a reference number and provide their feedback.
- Text message: patients are given (sent) the two questions, plus an explanation, and are asked to text their reference number and response to a dedicated number. Explanatory note should be clear that this is a dedicated survey number not used for anything else.
- Telephone survey: patient is given information and must be informed that that interviewer is not connected to the practice, participation is voluntary and that their responses will remain anonymous.

(* The contractor should survey at least 2% of the practice list size and need to get a minimum of 50 responses. It is for the practice to decide how many patients to approach in order to achieve 50 responses.)

Selecting Patients to Survey

The Recommendation Question is not designed to be used to determine the experience of different groups but practices should assure themselves and the Board that the chosen methodologies are not disproportionately affecting return rates for particular groups. It may be necessary to offer more than one method to avoid under-representation of certain groups (for example, relying on text messages may lead to under-representation from older patients).

Consider: age, sex, disability, ethnicity and IT skills. Hard to reach groups may include, but are not limited to, those with Dementia, Learning Difficulties and patients whose first language is not English. The overall approach to sampling should help to ensure that feedback is representative.

The contractor report should include:

- Short paragraph on survey methods chosen to include how patients who have had differing contacts with the practice (face to face or telephone consultation or prescription) and how patients with differing age, sex, ability, ethnicity have been included as appropriate.
- Total number of patients invited to take part.
- Total number of responses received.
- Percentage of patients who gave each possible category of response (6 numbers totalling 100).
- Short paragraph on any feedback to patients and actions taken as a result of this survey.

Section 7: QOF Queries process

Queries can be divided into three main categories:

1. those which can be resolved by referring to the guidance and/or FAQs
2. those which require interpretation of the guidance or Business Rules
3. those where scenarios have arisen which were not anticipated in developing guidance.

Within these categories, there will be issues relating to coding, Business Rules, payment, PCAS, clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas.

If there are queries which cross the above areas, the recipient of the query will liaise with the other relevant parties in order to resolve/respond. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

Where an issue relating to clinical indicators has arisen mid-year that cannot be resolved with simple clarification of the guidance, this will fall in to the process of reviewing QOF indicators.

QOF queries should be directed as follows:
In Northern Ireland queries should be directed in the first instance to the HSCB Area Lead Contact for resolution. If queries cannot be resolved then the HSCB will liaise with the Department of Health and NI GPC for an agreed response.

Section 8: Exception reporting guidance

Purpose of guidance

Exception reporting was introduced into the QOF in 2004. It is intended to allow contractors to pursue the quality improvement agenda without being penalised for patient specific clinical circumstances or other circumstances beyond the contractor's control which lead to failure to achieve the indicator. For example, where a medication cannot be prescribed due to a contra-indication or side-effect, where patients do not attend for review or where secondary care services are not available.

Since 2004, it became clear that a variety of interpretations and applications of the nationally defined exception reporting criteria are possible. NHS Employers and the BMA published guidance in October 2006 regarding what constitutes good practice in exception reporting. The 2006 guidance was designed to provide additional clarity, to the information contained in the QOF guidance, in order to help maintain a consistent approach to exception reporting.

From April 2013, the exception reporting guidance has been updated and supersedes any previous guidance issued. It is supplementary to the paragraphs included in section one of this document.

Principles

The overriding principles to follow in deciding to except a patient are that:

- The duty of care remains for all patients, irrespective of exception reporting arrangements.
- It is good practice for clinicians to review from time to time those patients who are excepted from treatment e.g. to have continuing knowledge of health status and personal health goals.
- The decision to exception report should be based on clinical judgement, relevant to the patient, with clear and auditable reasons coded or entered in free text on the patient record.
- There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

In each case where a patient is exception reported, in addition to recording what should be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the clinical reason for the exception is fully recorded in a way that can facilitate an audit in the patient record. This is both in order to manage the care of that particular patient and for the purpose of verification.

Definitions

There is an important distinction to be made between "exclusions" and "exceptions". This guidance is about "exceptions".

Exclusions are patients on a particular clinical register, but who for definitional reasons are not included in a particular indicator denominator. For example, an indicator (and therefore the denominator) may refer only to patients of a specific age group, patients with a specific status (e.g. those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

Exceptions are patients who are on the disease register and who would ordinarily be included in the indicator denominator. However they are excepted from the indicator denominator because they meet at least one of the exception criteria set out in the SFE. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice.

The criteria under which a patient may be excepted from a QOF indicator are set out in the SFE and also in section one of this document.

Although the SFE sets out nine reasons why a patient may be exception reported, the national QOF achievement analysis system identifies exception reporting against a limited number of codes. For example, criteria A and G are both coded as "informed dissent" or "patient refused". Any patient is only excepted once by the system for a given indicator, but any patient's clinical record could contain more than one type of exception reporting Read code entered by the contractor. It is therefore not possible to extract completely accurate or meaningful data on exceptions broken down by each of the criteria defined in the SFE from the national systems. Therefore the HSCIC only reports the total numbers of patients excepted for each indicator.

For the purposes of managing the care of the patient and for subsequent audit and verification, it is important that the reason the patient meets one or more of the exception reporting criteria and any underlying clinical reason for this is recorded in the patient's clinical record. For example, where a patient has not tolerated medication, the nature of the contraindication should be recorded in the patient's notes as well as the exception reporting code applied.

Detailed guidance on exception reporting

Each of the nine criteria for exception reporting are detailed below:

A. Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the financial year to which the achievement payments relate (except in case of indicator CS002NI, where the patient should have been invited on at least three occasions during the period of time specified in the indicator during which achievement is to be measured (i.e. the preceding 5 years ending on 31 March in the financial year to which achievement payments relate).

Invitations to attend a review should be made to the individual patient and can be in writing or by telephone. This can include a note at the foot of the patient's prescription requesting that they attend for review.

The three invitations need to have taken place within the financial year in question (e.g. 1 April 2016 to 31 March 2017 if applying to the year 2016/17). There should be three separate invitations at three unique periods of time. The only exception to this rule is indicator CS002NI, where the period in which the three invitations are sent reflects the timeframe of the indicator i.e. five years.

The telephone call invitation may lead to the application of exception criterion G, 'informed dissent', if the patient refuses to take up the invitation to attend.

The following are examples that are not acceptable as an invitation:

1. A generic invitation on the right hand side of the script to attend a clinic or an appointment e.g. influenza immunisation.

2. A notice in the waiting room inviting particular groups of patient to attend clinics or make appointments (e.g. influenza immunisation).

Influenza immunisation indicators
Exception reporting for influenza immunisation has caused some confusion because it is also remunerated through a NILES. For the NILES, payment is based on the number of at-risk patients immunised. The NILES nevertheless requires the contractor to develop a proactive approach and a robust call and reminder system for the at-risk groups.

For QOF, the payment is based on the percentage of patients immunised in each relevant disease area. Exception reporting rules apply to the QOF indicators and patients need to have been personally invited on at least three occasions that year to be excluded from the denominator for achievement under criterion A.

Cervical screening indicators
Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criterion A require that three separate invitations are offered to the patient before that patient can be recorded as 'did not attend'. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA; or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

The exception reporting criterion is not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all three

invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman to be exception reported for this period, criterion G requires that a discussion has taken place between the patient and the practitioner before 'informed dissent' can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

B. Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness, extreme frailty.

The overriding principle is that blanket exception reporting is not acceptable and individual decisions based on clinical judgment should be made.

It is not acceptable to exclude all patients above a certain age or all those with a particular diagnosis e.g. dementia or cancer. However, age, diagnosis, co-morbidity, health and functional status should be taken into account when deciding whether to exception report individual patients under this criterion.

In each individual case there is a question of degree which requires clinical judgement to be exercised.

C. Patients newly diagnosed or who have recently registered with the contractor, who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels.

Exception reporting is done automatically through the national achievement analysis system. Where the contractor has delivered the appropriate clinical standard within the timeframe for the indicator, the achievement would automatically override the exception.

D. Patients who are on maximum tolerated doses of medication whose levels remain sub-optimal.

The over-riding principle is that blanket exception reporting is not acceptable and each case is to be considered on its own merits, making a clinical judgment (see criterion B).

It is not acceptable to exclude all patients who are under the care of a consultant. Each case needs to be carefully considered and all reasonable efforts made to provide optimal care.

Even when a patient is under the care of a consultant only, the contractor should ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the contractor should assume that the action has not been carried out. The patient should not be exception reported on the basis that they are under the care of a consultant. The contractor should either fulfil the requirements of the relevant

indicator(s) or obtain evidence from secondary care that the particular test/check has been carried out. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, exception reporting will be allowed. This should be noted in the patient record.

E. Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contra-indication or have experienced an adverse reaction.

The nature of the contra-indication, allergy or adverse drug reaction should be recorded in the patient record as well as the exception reporting code applied.

F. Where a patient has not tolerated medication.

The nature of the intolerance should be recorded in the patient record as well as the exception reporting code applied.

G. Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.

A personal contact or discussion should be documented in the patient's record for this criterion to apply. This can include either face-to-face or telephone contact between a health professional and the patient.

Patients not responding to invitations to attend or failing to arrive at appointments cannot be exception reported under criterion G, i.e. DNA alone does not fulfil the criteria for informed dissent. Patients failing to respond after three invitations can be exception reported under criterion A.

The informed dissent should have been given in the period 1 April 2016 to 31 March 2017 if applying to the year 2016/17, (except cervical screening where a patient has withdrawn from the call and recall system).

H. Where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease.

The nature of the supervening condition should be recorded in the patient's notes as well as the exception reporting code applied.

I. Where an investigative or secondary care service is unavailable.

The contractor would be expected to explore fully with their ICP whether or not a suitable investigative or secondary service could be commissioned for the patient prior to deciding to except them on the basis that the service was unavailable.

Section 9: Glossary of terms

Abbreviation	Definition
ABPI	Ankle Brachial Pressure Index
ABPM	Ambulatory Blood Pressure Monitoring
ACCORD	Action to Control Cardiovascular Risk in Diabetes
ACE-Inhibitor or ACE-I	Angiotensin Converting Enzyme Inhibitor
ACR	Albumin:Creatinine Ratio
ACS	Acute Coronary Syndrome
ACTIVE-W	Atrial Fibrillation Clopidogrel Trial with Irbesartan for Prevention of Vascular Events
ADA	After Death Analysis
AED	Antiepileptic Drugs
AF	Atrial Fibrillation
AMA	American Medical Association
APHO	Association of Public Health Observatories
ARB	Angiotensin Receptor Blocker
AST	Asthma
ATC	Antithrombotic Trialists Collaboration
BAFTA	Birmingham Atrial Fibrillation Treatment of the Aged
BDI-II	Beck Depression Inventory, second edition
BHSOC	British Hypertension Society
BLS	Basic Life Support
BMD	Bone Mass Density
BMA	British Medical Association

BMJ	British Medical Journal
BNF	British National Formulary
BP	Blood Pressure
BPA	Bio-psychosocial Assessment
BTS	British Thoracic Society
CABG	Coronary Artery Bypass Grafting
CAD	Coronary Artery Disease
CAN	Cancer
CBT	Cognitive Behavioural Therapy
CHD	Coronary Heart Disease
CHS	Child Health Surveillance
$CHADS_2$	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke
CI	Confidence Interval
CKD	Chronic Kidney Disease
CMO	Chief Medical Officer
CON	Contraception
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CRP	C-Reactive Protein
CS	Cervical Screening
CVD	Cardiovascular Disease
CVD-PP	CVD Primary Prevention
DBP	Diastolic Blood Pressure
DCCT	Diabetes Control and Complications Trial
DH	Department of Health
DEM	Dementia

DEP	Depression
DM	Diabetes Mellitus
DNA	Did Not Attend
DRS	Diabetic Retinopathy Screening
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, fourth edition
DXA	Dual-Energy X-ray Absorptiometry
ED	Erectile Dysfunction
EHC	Emergency Hormone Contraception
eGFR	Estimated Glomerular Filtration Rate
EOLC	End of Life Care
EPIC	European Prospective Investigation into Cancer
ERJ	European Respiratory Journal
ESR	Erythrocyte Sedimentation Rate
FBC	Full Blood Count
FEV_1	Forced Expiratory Volume in One Second
FVC	Forced Vital Capacity
GFR	Glomerular Filtration Rate
GMP	Good Medical Practice
GMS	General Medical Services
GOLD	The Global Initiative for Chronic Obstructive Lung Disease
GP	General Practitioner
GPC	General Practitioners Committee
GPPAQ	GP Physical Activity Questionnaire
GPRD	General Practice Research Database
GPwSI	GP with a Special Interest
GSF	Gold Standards Framework

HAD-D	Hospital Anxiety and Depression Scale Depression Sub-Scale
HADS	Hospital Anxiety and Depression Scale
HbA1c	Glycated Haemoglobin
HBPM	Home Blood Pressure Monitoring
HDA	Health Development Agency
HF	Heart Failure
HSCIC	NHS Health and Social Care Information Centre
HYP	Hypertension
ICP	Integrated Care Partnership
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
IUD	Intrauterine Device
IUS	Intrauterine System
JBS	Joint British Societies
JCVI	Joint Committee on Vaccination and Immunisation
LARC	Long Acting Reversible Contraception
LDL	Low Density Lipoprotein
LMC	Local Medical Committee
LVSD	Left Ventricular Systolic Dysfunction
MAT	Maternity
MCM	Major Congenital Malformation
MH	Mental Health
MI	Myocardial Infarction
mmHg	Millimetres of Mercury
mmol/l	Millimoles per Litre
MR	Modified Release
MRC	Medical Research Council

MRI	Magnetic Resonance Imaging
NAO	National Audit Office
NEJM	New England Journal of Medicine
NHANES	National Health and Nutrition Examination Survey
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
NPV	Negative Predictive Value
NRT	Nicotine Replacement Therapy
NSAIDs	Non-Steroidal Anti-Inflammatory Drugs
NSF	National Service Framework
OGTT	Oral Glucose Tolerance Test
ONS	Office for National Statistics
OST	Osteoporosis
OTC	Over The Counter
PC	Palliative Care
PCR	Protein:Creatinine Ratio
PE	Patient Experience
PEF	Peak Expiratory Flow
PHQ-9	Nine Item Patient Health Questionnaire
PCRJ	Primary Care Respiratory Journal
PVD	Peripheral Vascular Disease
PCAS	Payment Calculation and Analysis System
QOF	Quality and Outcomes Framework
QP	Quality and Productivity
RA	Rheumatoid Arthritis

RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
RCN	Royal College of Nurses
RCTs	Randomised Controlled Trials
Regional Board	Health and Social Care Board
SCR	Supportive Care Register
SIGN	Scottish Intercollegiate Guidelines Network
SMOK	Smoking
SSRI	Selective Serotonin Reuptake Inhibitors
STIA	Stroke or Transient Ischemic Attack
TIA	Transient Ischemic Attack
THY	Thyroid
TPCR	Total Protein: Creatinine Ratio
TSH	Thyroid Stimulating Hormone
UK	United Kingdom
WHO	World Health Organisation